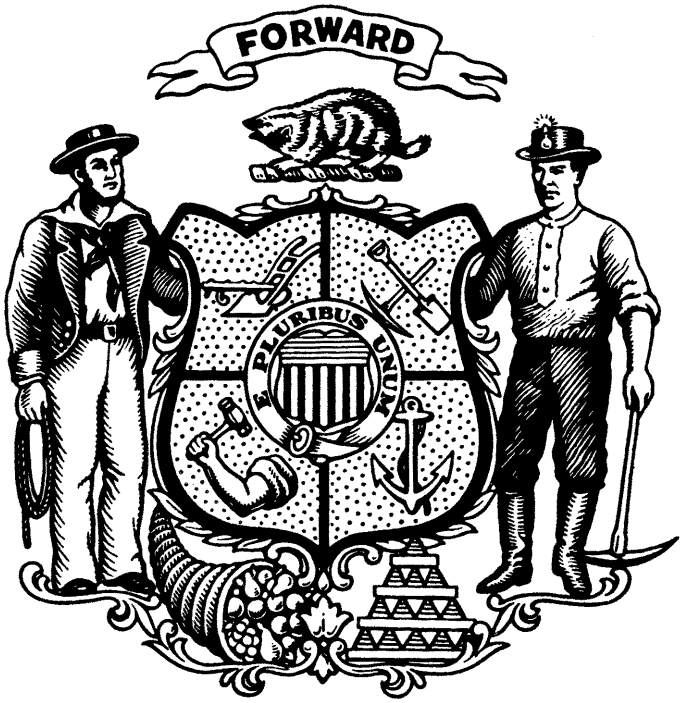
State of Wisconsin
Department of Health and Family Services



Request for Consideration
Mental Health/Alcohol and Other Drug Abuse Managed Care
Division of Health Care Financing
Division of Supportive Living

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Mental Health/Alcohol or Other Drug Abuse Managed Care

I. STATEMENT OF PHILOSOPHY

A. Introduction

The Department of Health and Family Services (DHFS) is seeking counties and tribes, individually or in consortia with other public or private entities, to demonstrate managed care systems for persons with mental health and/or alcohol and other drug abuse disorders. This Request for Consideration (RFC) will address the following areas:

- The background and planning for this project.
- The goals of the demonstrations.
- An overview of the system we seek to demonstrate.
- The requirements counties/tribes must meet for the demonstrations.
- The funding and other resources available to demonstration counties/tribes.
- Information about responding to this RFC.

Planning for this project began within the DHFS (then the Department of Health and Social Services) in the fall of 1995. Department Deputy Secretary, Richard Lorang directed the Bureau of Community Mental Health, the Bureau of Substance Abuse Services and the Bureau of Health Care Financing (now the Division of Health Care Financing) to form a workgroup to explore managed care for persons with mental illness and substance abuse disorders. In April 1996, the Department released a concept paper, "Designing Managed Care Models for Persons with Mental Illness and Substance Abuse"[1]. This concept paper articulated the problems that managed care would attempt to remedy, the vision and operating assumptions, the target populations, the desired objectives, and structural options for implementing managed care models.

It was shortly after the release of this concept paper that the Governor's Blue Ribbon Commission on Mental Health was appointed.

[1] Unless otherwise specified documents referenced in this RFC can be found on the DHFS website. You can access the website at www.dhfs.state.wi.us/LTCare/related.htm.

B. History of the Blue Ribbon Commission

The Governor's Blue Ribbon Commission on Mental Health (BRC) was appointed in May 1996. The Governor's charge to the BRC was to examine the mental health delivery system and the principle of a state/county partnership; the mental health services provided for children, adolescents, adults, and the elderly; and the impact of stigma on community perceptions and current mental health policies.

The Executive Order creating the BRC further directed it to:

- Recommend model mental health delivery systems that are effective in an environment that emphasizes managed care, client outcomes, and performance contracting;
- Recommend ways the federal, state, and county governments can cooperate to gain fiscal efficiencies and greater service capacity;
- Recommend a service system targeted at prevention, early intervention, treatment, recovery, and positive consumer outcomes; and
- Recommend ways to reduce stigma in Wisconsin's mental health policies and programs.

BRC membership included all key Wisconsin stakeholder groups interested in mental health services for the state's citizens. Members represented public and private service providers, county and state elected officials, consumers (that is, persons who receive or have received mental health services), family members of consumers, advocates, the judicial community, and insurance and hospital groups.

The BRC met monthly from June 1996 until February 1997. It created three committees and several short-term work groups to develop special reports. The BRC sought broad public input from a total of more than 700 persons. Its final report was issued in April 1997.

C. Vision, Mission and Guiding Principles

The vision, mission and guiding principles of the BRC addressed mental health services only, as was consistent with the charge of the commission. However, during the planning process for these demonstrations, the vision, mission and guiding principles were reviewed for their relevance to persons with alcohol and other drug abuse disorders. The revised vision, mission and guiding principles can be found in Attachment 1. The DHFS has attempted to develop policies for the demonstrations consistent with this document and intends to incorporate these concepts into our contracts with demonstration sites.

D. Key Recommendations of the BRC

Among the recommendations of the BRC are the following:

- The mental health system must be consumer and family-focused and recovery-oriented. While recovery for any individual is a deeply personal experience, the goal of a recovery-oriented system is for individuals to attain a productive and fulfilling life regardless of mental illness or substance abuse disorder.

- Three diagnoses should be priority targets for specific prevention and early intervention activities:

  - ✓ Conduct disorder in children;

  - ✓ Depression in all age groups; and

  - ✓ Post-traumatic stress disorder in all age groups.

- Mental health service system planning should be guided by the identification of five target population groupings which are based on a level of a person's service need. See Attachment 2 for a description of these target populations.

- A comprehensive range of services must encompass not only traditional mental health (e.g., outpatient clinic and intensive in-home) and in-resident (e.g., hospital and crisis) services, but also two additional groups of services essential to both recovery and to the accomplishment of successful community living outcomes:

  - ✓ Self-help, peer support, and natural supports, and

  - ✓ Community supportive services (e.g., vocational development, parenting skills training, money management).

- All consumers should participate in a comprehensive assessment; receive highly individualized services based on that assessment and the consumer's chosen way of life; have a plan of services designed to achieve positive consumer outcomes, including self-sufficiency; be served with dignity, respect, and the least restrictive interventions necessary to achieve consumer outcomes; and receive services that meet any applicable standards of care.

- Merge the three major sources of funding for mental health services (State Community Aids, County Funds, and Medicaid) in order to provide comprehensive services for mental health treatment, recovery, and prevention and to assure that "money follows the consumer."

- Maintain and build upon existing linkages between county mental health systems and other county-coordinated human and "safety net" services, including child welfare, criminal justice, adult protective services, etc.

- Maintain and build upon local investments in community mental health: county funding, county risk bearing, citizen involvement, and natural support networks.

- Develop improved data systems to guide decision making as changes in the mental health system are implemented. Specifically, data needs include: the per person cost of services funded by community aids, county tax funds, and Medicaid; consumer outcomes; and performance contract details.

- Implement the redesigned mental health system in incremental steps to minimize disruptions in services to consumers. The "First, Do No Harm" principle should guide system change.

- The redesigned mental health treatment system should have measurable, useful consumer outcome performance indicators, including self-reports by consumers. The BRC identified 15 consumer outcomes in three domains: energizing outcomes, community living outcomes and clinical outcomes.

E. Goals of the Demonstrations

Reflecting both the objectives outlined in the concept paper and the recommendations of the BRC, the DHFS has identified the following goals for the demonstrations:

- Implement the principles outlined in the final report of the Governor's Blue Ribbon Commission on Mental Health (BRC).

- Incorporate the concept of recovery into the system of care.

- Increase the emphasis on prevention and early intervention.

- Increase consumer, family, and advocate involvement at all levels of the system, including policy and decision-making, service delivery and evaluation.

- Integrate federal, state and local funding for MH and AODA services to create a comprehensive and very flexible system of care. Currently, the rules that accompany some funding, especially Medicaid, make it difficult to provide individuals with the services they might need and want, when and where they need them.

- Use managed care techniques to improve the quality of care, outcomes of care, accountability for care and realize a reduced rate of growth in expenditures for the state and counties.

- Better integrate or coordinate a person's physical health care needs with his or her MH or AODA treatment needs.

- Better integrate or coordinate MH services with AODA services.

- Improve access to services and minimize the differences in access and availability of services to the target populations that currently exist across the state.

- Build on the county/tribal role in organizing MH/AODA care

F. Consumer Bill of Rights and Responsibilities

Based on the recommendations of the BRC, the demonstrations will use a recovery-oriented system of care to support the consumer's active and informed involvement in his or her treatment and recovery process. Such involvement must support a consumer's right to information, choice and dispute resolution. It must also recognize that as a consumer's involvement in recovery increases, so does his or her responsibility for the treatment and recovery process. To this end, the DHFS has adopted a consumer bill of rights and responsibilities that we intend to incorporate into our contracts for demonstration sites. A copy of the bill of rights and responsibilities can be found in Attachment 3.

The MCO will be required to produce an enrollee handbook that will inform enrollees of these rights and responsibilities, as well as other information about obtaining services through the MCO. The handbook must be approved by the DHFS. Requirements for information to be included in the enrollee handbook are contained in the draft managed care contract accompanying this RFC.

II. DEVELOPMENT OF THE REQUEST FOR CONSIDERATION (RFC)

A. Oversight and Management

1. Blue Ribbon Commission Implementation Advisory Committee

Consistent with the recommendations of the BRC, the DHFS appointed a Blue Ribbon Commission Implementation Advisory Committee (BRC-IAC) which first met in October 1997. The purpose of this committee was to oversee and advise the DHFS regarding implementation of the BRC recommendations. In order to have the BRC-IAC function in an oversight capacity for the MH/AODA managed care demonstration projects, representatives from MH consumer, provider and advocacy groups were supplemented with comparable representatives from the AODA community. The membership of the BRC-IAC can be found in Attachment 4.

The BRC-IAC has met bi-monthly, or more often when needed, to review issues relevant to implementing the recommendations of the BRC and to make its own recommendations to the DHFS. Three workgroups have been formed to address specific issue areas: legislation; recovery and consumer/family involvement; and prevention and early intervention. While the charge for these workgroups is to develop strategies for the statewide implementation of BRC recommendations, these workgroups have also been making specific recommendations for the MH/AODA managed care demonstration projects. (See the project flowchart in Attachment 5. This flowchart identifies the various workgroups discussed here and in the remainder of this section and illustrates their relationship to one another.)

2. MH/AODA Managed Care Steering Committee

Within the DHFS, the management and oversight of the MH/AODA managed care demonstration projects has been handled through an internal steering committee consisting of management and program staff from the Division of Supportive Living, the Division of Health Care Financing and the Office of Strategic Finance. From the inception, the collaboration of the state agencies for mental health, alcohol and other drug abuse, and Medicaid has been at the core of the planning effort. This collaboration recognizes the strengths and expertise that each agency brings to the planning effort. Involvement of all three agencies is also meant to ensure that the recommendations and requirements contained in this RFC reflect the programmatic priorities of each agency and are consistent with the regulations governing each agency.

The DHFS has also wanted to ensure strong coordination with Family Care, the redesign of the long-term care system. This coordination is meant not only to benefit the planning for each effort by avoiding redundancy in planning, it is also meant to ensure that the two initiatives can "fit together" well at the local level if a given site is implementing both programs. The DHFS wants to ensure that, where possible, basic structural elements-management information system and reporting procedures, grievance procedures, etc.-are compatible, if not identical.

3. Executive Teams

Executive Teams (ET) consist of high-level management staff from key DHFS agencies. A Long-Term Care (LTC) ET oversees the Family Care project (and initially reviewed key issues for MH/AODA managed care). More recently a MH/AODA managed care ET was developed to oversee the MH/AODA managed care demonstration projects. (During the early phases of planning for these initiatives, the MH/AODA managed care demonstration projects were viewed as a part of the long-term care redesign and the BRC was considered to be the disability reference group for mental health. Over time the two projects have come to develop in a more distinct, but parallel fashion.) The DHFS Secretary and Deputy Secretary are often part of the LTC-ET meetings.

Recommendations from the BRC-IAC that have been reviewed by the steering committee are forwarded to the ET when management staff on the steering committee determine such review is needed. Ultimately the DHFS Secretary has final decision-making authority with regard to requirements contained in this RFC.

B. Request for Letters of Interest and Selection of Planning Partners

Shortly after the appointment of the BRC-IAC, the DHFS began its formal planning process for the MH/AODA managed care demonstration projects. Anticipating the need for additional financial resources to support this process, the DHFS had applied for funding from the Robert Wood Johnson Foundation (RWJF) late in 1996. A feasibility grant was ultimately awarded through the Center for Health Care Strategies (CHCS), a program of the Woodrow Wilson School of Public Administration at Princeton University. As part of the process for award of these funds, CHCS recommended that we involve counties and tribes in our planning efforts to ensure that any program requirements would make sense and be "doable" at the local level. This recommendation was reviewed with the BRC-IAC, which found this recommendation to be consistent with the BRC recommendation to build the redesigned system on the existing local systems of care.

The DHFS worked closely with a group of individuals appointed by the BRC-IAC to develop a process for selecting counties and tribes. The original intent was to select counties and tribes that would be the actual demonstration sites. However, through the process of working with county representatives from the BRC-IAC the DHFS determined that county boards would be extremely unlikely to be willing to commit themselves to a demonstration project without considerably more information on what would be required of counties/tribes than we had available at the time. As a result, we decided that the intent of the selection process would be to find counties/tribes interested in working with the DHFS to develop recommendations for policies and requirements for the demonstration projects.

In January 1998, the DHFS issued a Request for Letters of Interest in Developing Behavioral Health[2] Managed Care Program Features (RFLI) to all Wisconsin counties and tribes. Ten "sites" responded with proposals. These sites consisted of either single counties, multiple counties or, in one case, a county and a tribe together. The sites represented 21 counties and one tribe. Additionally, the sites represented a variety of rural and urban settings. Finally, the sites represented a variety of potential approaches to implementing MH/AODA managed care. A summary of the sites and their proposals can be found in Attachment 6.

The responses to the RFLI were reviewed and evaluated by two review committees consisting of DHFS staff, consumers, families, county administrators (from non-applying counties) and other impartial individuals. The DHFS decided to invite all 10 sites submitting proposals to participate in the planning process. However, the six sites with the highest evaluation scores were invited to bring teams of county staff, key providers, consumers and families. The other sites were limited to two representatives each.

C. Overview of the Planning Process

The DHFS initially formed two planning groups with the representatives from the county/tribal planning partners and DHFS staff: 'Fiscal Issues' and 'System and Benefit Design'. Over time these two groups merged and the following smaller workgroups were formed to address discrete issues (also see flowchart in Attachment 5):

- Screening and Enrollment
- Care Planning
- AODA Issues
- Medicaid Capitation Rate and County Share

[2] The DHFS originally used the term "behavioral health" to identify the combination of mental health and alcohol and other drug abuse services. This is common terminology within the health care field. However, at the request of consumers and families, we discontinued use of this term in favor of "mental health/AODA" managed care.

- Resource Centers
- Quality Improvement

In addition, the DHFS has organized other workgroups distinct from this planning process with the county planning partners. These included:

- Consumer Outcomes (started December 1997)
- Children's Issues
- Evaluation Planning
- Management Information Systems and Reporting

The involvement of consumers and families has been integral to the planning process. In order to ensure that consumers and families could provide active and informed participation, the DHFS contracted with We-CARE, a coalition of mental health consumer, family, and advocacy groups to conduct consumer and family trainings. Six trainings were held across the state in August 1998. The trainings provided attendees with background information on the MH/AODA managed care project (including the BRC recommendations), basic information on managed care language and principles and guidance on the consumer and family role on planning and policy-making groups. About 120 individuals participated in these trainings. The DHFS continues to draw from this group as we identify a need for additional consumer involvement (e.g., focus groups).

D. Information Sharing

The BRC-IAC and the DHFS steering committee reviewed recommendations from the planning groups. Additionally, the DHFS has shared information on policy through updates to interested parties. Updates were sent in January and December 1998, to a large mailing list of county and tribal staff, provider agencies, consumer and family groups, managed care organizations and others. A 'Frequently Asked Questions' document was posted on the DHFS website, along with other documents related to the demonstration projects. DHFS staff have participated in a number of conferences and meetings of stakeholder groups to describe the proposal and likely requirements for the RFC. Finally, the DHFS held regional information meetings in the Spring of 1999 to provide further information about the RFC and obtain comments on the proposal. A draft of this RFC was widely circulated and placed on the DHFS website. Comments on the RFC were solicited and numerous changes have been made to the RFC in response to these comments (see list of substantive changes from draft RFC in Attachment 37).

III. OVERVIEW OF THE PROPOSAL AND PROGRAM REQUIREMENTS

A. The Umbrella Design

1. Description

In order to meet our goal of integrating all public funding for MH and AODA services, we need to merge two distinct but overlapping systems of care: the Wisconsin Medicaid program and the 51.42 system. The Wisconsin Medicaid program is a health care program for certain groups of individuals who are eligible based on federal and state regulations. Eligible persons include, for instance, persons receiving Supplemental Security Income (SSI) and children in foster care. Once eligible for Medicaid, individuals are entitled to certain services covered by the Medicaid program (assuming all program requirements are met). This means that Wisconsin Medicaid must pay for covered services which meet all program requirements for payment.

The DHFS recognizes that counties and tribes do not serve an *enrolled* population, in the sense this term is understood by Wisconsin Medicaid or the private insurance market. The county or tribe is potentially responsible for providing MH and AODA services to any individual residing in their county or tribe, as well as individuals who may be visiting or passing through. Recognizing this, the statutes creating the 51 system have limited the liability of counties and tribes to the amount of state community aids and the required local match to these funds (although many counties provide additional funding to the system). Counties and tribes identify priority populations for services, as well as allocating funds for emergency services for other individuals.

These systems overlap to the extent that counties provide services to Medicaid-eligible individuals. Counties operate as both Medicaid service providers who bill Wisconsin Medicaid for Medicaid-covered services as well as payers of services that are not covered by Wisconsin Medicaid.

Through the planning process, counties have expressed concern about any proposal that would create a new entitlement to services that does not currently exist. Such an entitlement, in the absence of new service funding, could put counties and tribes at considerable financial risk. At the same time, the DHFS wishes to develop the system consistent with the recommendations of the BRC without jeopardizing services to any populations currently served by the counties and tribes. Furthermore, most of the advantages of managed care-capitated rates, accountability, quality improvement-are dependent upon an identified or enrolled population.

The resulting proposal is a hybrid that attempts to balance these issues and concerns. It merges the two systems but continues to recognize the different requirements that apply to individuals based on their Medicaid eligibility. The DHFS proposes to contract with counties or tribes, or partnerships of counties/tribes and private organizations for managed care services that will overlay the entire publicly funded MH/AODA system (both the 51.42 system and Medicaid). However, the managed care organization (MCO) will have two components:

- *A prepaid, capitated component.* Persons in BRC target populations 1 and 2, including those with co-occurring substance abuse disorders, will be eligible for enrollment in this component, *regardless of their Medicaid eligibility*. This population is one that both the DHFS and counties/tribes believe the counties/tribes are now serving (with the exception of some Medicaid-eligible individuals who may be receiving services solely through private sector providers). Enrollment will be voluntary on the part of the consumer. Counties/tribes will receive a Medicaid capitation for each Medicaid enrollee to this component. Based on criteria developed through the planning process and through further work with the demonstration sites selected in response to this RFC, the county/tribe will identify a contribution of community aids/tax levy representing the estimated amount of these funds used to serve this population currently (both those receiving Medicaid and those not receiving Medicaid). Enrollment will include non-Medicaid eligible individuals meeting the target population criteria, with funding from the county/tribe to serve this group. All funding for non-Medicaid eligibles will be from funds administered by the county.

  While moving to capitation is a goal of the demonstrations, the DHFS envisions an 18 month period between the point at which start-up funds are available and the point at which the MCO will begin enrolling people into prepaid, capitated managed care. Secs. V and VI of this RFC provide more information on this process. Attachment 7 identifies which of the requirements described in this RFC will apply to demonstration sites during each phase of this process.

- *A non-capitated component*. All other populations currently served through the publicly-funded system—BRC target population 3 and all other AODA populations (those without a co-occurring mental illness)—will be funded as they currently are. Persons who meet BRC target population 1 and 2 but who choose not to enroll in the prepaid, capitated component will also be served in this non-capitated component. Medicaid will be accessed on a fee-for-service basis for Medicaid enrollees and counties/tribes will continue to provide matching funds for services they currently match (e.g., CSP, case management). The DHFS

expects counties/tribes to continue to serve at least the populations they currently serve. Counties and tribes will be required to describe, in their proposals, how they define these populations.

The MCO will be responsible for the following activities across both components of the organization (capitated and non-capitated):

- Implementing recovery and consumer and family involvement recommendations (see Secs E and F. for further details).

- Developing information systems capable of tracking and reporting service utilization and costs by individual, by funding source, across all programs (see Sec. H, 2). This will help to assure we have accurate data for rate-setting and will give us better data for moving additional populations into prepaid managed care.

The MCO will be responsible for meeting all specified system of care requirements in Sec. D., and Quality Improvement Requirements in Sec. G for the prepaid, capitated component of the organization.

Proposers will identify strategies they will incorporate into the non-capitated component to improve the system of care. Scoring for the proposals will reward proposers who incorporate a fuller array of strategies into the non-capitated component. Examples of strategies that were identified by the planning group include:

- Enhance care management functions in the non-capitated part of the system. Examples include:

  - ✓ Identifying high users of AODA services and providing enhanced case management for these individuals.

  - ✓ Identifying individuals with repeated use of crisis services and assessing for other services that will reduce the repeated use of crisis services.

- Incorporate the same quality improvement mechanisms for non-capitated enrollees as for capitated enrollees.

- Utilize performance-based contracting for the providers of services to the non-capitated population.

- Use the comprehensive assessment and care planning for some portions of the non-capitated population.

The proposer may phase-in these enhancements over time.

A diagram illustrating this organization design is found in Attachment 8. A table displaying eligibility and funding criteria for each component is found in Attachment 9.

2. Rationale

This design incorporates a number of important principles developed during the planning process:

- It builds on the recommendations of the BRC, especially by incorporating consumer and family involvement and recovery concepts throughout the entire publicly-funded system of care.

- It prioritizes services based on functional need (by using the BRC target population definitions to define eligibility for the prepaid managed care component) rather than on diagnosis or funding source.

- It allows the county/tribe to indicate how it will accomplish certain objectives, where possible, rather than prescribing everything at the State level. This ensures that counties and tribes can develop their service system in ways that make sense given the unique point from where they are starting.

- It supports incremental development of the service system (which was also a recommendation of the BRC) by:

  ☞ Beginning with a phase in period as better utilization and expenditure information is developed and other programmatic changes begin.

  ☞ Enrolling only a portion of the population into prepaid, capitated managed care initially.

  ☞ Incorporating some managed care principles into the non-capitated component.

  The DHFS anticipates that as we obtain better information about the utilization and expenditures associated with the individuals in the non-capitated portion of the population we will move these populations into the capitated component.

3. Carve-in vs. Carve-out Programs

The DHFS is interested in developing two service models for MH/AODA managed care. Carve-in models, also known as integrated models, would include all Wisconsin Medicaid covered services (MH/ AODA services and primary and acute care) for the Medicaid-eligible enrolled population (which will be referred to as Category A services) as well as the additional Category B and C services as described in Sec. E. below. Counties might also propose to include this same range of primary and acute care services for non-Medicaid eligible individuals. In this model the Medicaid capitation rate for the demonstration projects would reflect the cost to provide all Medicaid covered services to the Medicaid-eligible enrolled population (see Section V for a further discussion of the development of the capitation rate). However, the DHFS contract would still be with the county/tribe, which in turn would subcontract with an HMO to provide the primary and acute care.

Carve-out models would include mental health and AODA services only. This would include Medicaid-covered MH and AODA services, in addition to the Category B and Category C services, described below. The Medicaid capitation rate for these demonstration projects would reflect the cost to provide all Medicaid-covered MH and AODA services plus targeted case management to the Medicaid-eligible enrolled population. All other Medicaid-covered services for the Medicaid-eligible enrolled population will be available on a fee-for-service basis.

4. Persons with AODA disorders

Expanding the capitated portion of the MCO is of special importance for individuals with AODA disorders only. As is clear from the description above, during the initial stages of the demonstration projects enrollment into the capitated portion of the demonstrations will be limited to persons with mental health disorders only, or persons dually diagnosed with both mental health and AODA disorders. In part, this decision was influenced by the fact that most individuals with chronic AODA disorders are not Medicaid eligible[3], and therefore would bring no Medicaid capitation rate to support a move to a more flexible array of services. Also, good data on utilization and expenditures is not available for this group. However, the DHFS is committed to exploring possible Medicaid eligibility waivers that might allow us to extend Medicaid eligibility to some persons with chronic AODA disorders. As this will require better information about long-term utilization and costs of services, the improved data collection associated with the demonstration projects will be a necessary prerequisite

[3] Prior to 1996 it was possible for individuals with an AODA diagnosis only to receive Supplemental Security Income (SSI). This made these individuals automatically eligible for Medicaid. In 1996, Congress passed legislation removing AODA as an allowable disability for qualifying for SSI. Some individuals were able to continue eligibility for SSI due to a co-existing disability. Many, however, never sought a re-evaluation, or, if they did, did not qualify for continued SSI.

to this process. Counties and tribes may incorporate this group into the prepaid, capitated component earlier in the demonstration (with county-administered funds only), if they believe they can utilize the managed care structure to better serve these individuals.

5. County/Tribal Options

a. *Age Groups.* The county/tribe may choose to enroll individuals from one, two or three of the following age groups: children and adolescents (under age 18); adults (generally 18-64, but may be limited to 18-60); elderly (generally 65+, but may be 60+). The DHFS, upon the recommendation of the BRC-IAC, will give preference to proposals including all three age groups. If choosing to include more than one age group, the county/tribe may propose to phase in enrollment of the different groups (e.g., begin enrollment of adults in year one, children and adolescents in year two).

b. *Range of Medicaid eligibles.* Individuals become eligible for Medicaid in a variety of ways. Wisconsin Medicaid identifies individuals with medical status codes that signify the basis upon which they qualify for Medicaid. The largest portion of Medicaid-eligible individuals likely qualifying for MH/AODA managed care will be eligible based on receiving Supplemental Security Income (SSI). Some children will also be in this category. However, individuals with serious mental illness and substance abuse (to a lesser degree) may also qualify for Medicaid in other categories. See a complete listing of Medicaid eligibility categories in Attachment 10. Counties/tribes may wish to limit enrollment in the prepaid, capitated portion of the demonstrations to particular categories of Medicaid-eligibles and incrementally add groups of Medicaid-eligibles over time. Counties and tribes should especially consider whether they wish to include children in foster care and individuals in nursing facilities who are receiving specialized services for mental illness. This latter group of individuals would be appropriate for enrollment if the individual is evaluated as able and willing to move to a community-based setting.

6. Relationship to Family Care

a. Compatibility

As noted in Sec. II. A. 2 of this RFC, the DHFS has attempted to develop the MH/AODA managed care demonstrations to be compatible with Family Care in those counties that may become demonstration sites for both initiatives. This compatibility will be supported in a number of ways:

- Where possible, allowing the county/tribe to define how they will integrate the two initiatives (see, for instance, Sec. III. C. of this RFC).

- Seeking consistency in policies and requirements, where this makes sense (e.g., the Consumer Bill of Rights and Responsibilities for MH/AODA managed care was developed from the Family Care Consumer Bill of Rights and the two overlap to a large degree.)

- Focusing on defining the products or outcomes desired and limiting, where possible, the requirements as to how the county/tribe needs to achieve these products or outcomes. For instance, we define the data that the MCO must provide the DHFS and the capabilities of an information system, but do not mandate a particular information system. This allows the county/tribe to purchase/develop an information system that will meet the DHFS' requirements and also the needs of the county/tribe.

b. Eligibility

Certain individuals will meet the eligibility requirements for both Family Care and the MH/AODA managed care programs, e.g., persons who have both frailties of aging and a serious mental illness. The DHFS will continue to provide technical assistance to clarify the individual eligibility criteria for each program. However, an individual meeting the eligibility criteria for both programs may enroll in only one of the managed care programs. Persons who enroll in Family Care will be able to have their mental health or substance abuse treatment needs met either through the Family Care benefit package, the Medicaid-covered services that remain available on a fee-for-service basis, or through county/tribal funded services, as appropriate and available. Persons who enroll in MH/AODA managed care will have their long-term care needs met either through the MH/AODA managed care MCO (for integrated programs), through Medicaid fee-for-service (for carve-out programs) or through other programs and/or benefits available to the individual.

The DHFS will require that where a county/tribe is piloting both programs the county/tribe ensure the following:

- that the eligibility determination process be coordinated in a such a way that individuals are evaluated for their eligibility for both programs;

- that individuals are provided appropriate information about both programs, if they are eligible for both; and,

- that individuals are given a choice as to which program they would like to enroll into.

7. Coordination with Other Medicaid managed care programs.

a. AFDC[4]/Healthy Start/BadgerCare HMO Program

At this time AFDC/Healthy Start/BadgerCare eligibles in most areas of the state are required to enroll in a participating HMO. The DHFS will continue to require their participation in the AFDC/Healthy Start/BadgerCare HMO program. The DHFS will explore the possibility of allowing AFDC-related groups or BadgerCare enrollees to choose to receive their services through the MH/AODA managed care demonstrations, in those situations where HMO performance does not meet contract requirements.

However, counties and tribes can choose to open enrollment into MH/AODA managed care to those AFDC/Healthy Start/ BadgerCare eligibles who are not required to enroll in an HMO (either because no HMOs are participating in their area or they do not have a choice of HMOs) or who exempt out of the AFDC/Healthy Start/BadgerCare HMO. As with other individuals, enrollment will be voluntary on the part of the consumer.

[4] Although AFDC—Aid to Families with Dependent Children—has officially been replaced by TANF—Temporary Assistance to Needy Families—DHFS still refers to the group of low-income women and children using the older acronym.

b. Other Programs

The DHFS operates a number of other managed care programs for special populations. These include Wisconsin Partnership Program, I-Care, Children Come First and Wraparound Milwaukee. Because all of these programs are themselves voluntary, individuals may choose to enroll in one of these programs or in the MH/AODA managed care program if they meet the applicable requirements for each program (assuming the program's enrollment limits have not been exceeded).

However, if a county is operating a managed care program for children with severe emotional disturbance (SED) and the county is proposing to include children in their MH/AODA managed care demonstration, the SED program must be consolidated into MH/AODA managed care.

C. Enhancing the Front-End of the System

No system can be effective unless individuals who may need services can gain access to those services. This includes ensuring that consumers and families can readily access the information they need about the services and supports that may be available to them and can obtain these in a timely fashion, when needed.

Family Care has addressed these goals through the use of Resource Centers. Resource Centers are designed to be consumer and family friendly, "one-stop" shops where individuals can find out about the services that may be available to them, how to qualify for such services and receive assistance in this process. The BRC-IAC has recommended that at least one of the MH/AODA managed care demonstrations include a resource center similar to those developed through Family Care. This may, in fact, involve integrating mental health and AODA information and assistance into an existing Family Care Resource Center. The DHFS will seek to honor this recommendation in selecting MH/AODA managed care demonstration sites.

However, counties and tribes may also propose other approaches to enhancing access to information and services as long as they can demonstrate how such approaches will achieve one or more of the following goals:

- Increasing consumer and family access to services.*
- Providing better information, assistance and support to consumers and families.*
- Decreasing the need for emergency detentions/crisis services.
- Increasing the use of natural supports and local resources to keep people independent.

- Decreasing the degree to which consumers and families may feel they are "getting the run around."

- Increasing the alternatives available to consumers and families to meet their needs.

- Increasing the involvement of consumers and families in providing these front-end activities.

All sites must meet the two goals identified with an asterisk (*).

The planning group identified a number of potential strategies that could accomplish these goals:

- Early intervention/outreach teams, perhaps targeted at specific populations (e.g., the elderly, populations at risk for substance abuse). These outreach teams could be consumer-run and directed.

- Well publicized and visible access to consumer of all ages and family members.

- Consumer and/or family-run "warmlines." A warmline is an alternative to a crisis line. People can talk with warmline staff before a situation becomes a crisis, for problem solving, support or information. Warmline staff would be trained to know how and when to refer individuals to crisis services, if needed.

- Create a consumer or family-run "place" (similar to a resource center) where people can access information and assistance.

- Provide a full range of resources and benefits counseling that includes information about safe/affordable housing, education, employment, self-help, consumer-operated services and peer/family support.

- Involve consumers and families on existing crisis teams so that crisis intervention can be less threatening to consumers and families and perhaps more effective in reducing the need for involuntary actions (e.g., emergency detentions).

- Provide screenings for risk factors for mental illness or substance abuse.

- Screen for suicide risk among high at-risk groups of children, youth and older persons.

However, the manner in which a county or tribe seeks to achieve the goals noted above should be a product of local decision-making that includes consumers, families, providers and administrators at the local level.

Sites may propose to use a portion of their start-up funds to meet the requirements described in this section to the degree they are consistent with the allowable uses identified in Sec. IV. This should be identified in the project budget portion of Sec. VIII. of this RFC. Otherwise, no new funds are available to meet these requirements.

D. The System of Care

1. Screening Process

The planning group has drafted a screen that attempts to identify individuals eligible for the prepaid, capitated component of the managed care demonstrations (see Attachment 11). The screen was developed in such a way that it can be completed by qualified professionals within a county's/tribe's usual intake process. This screen is fairly short and can be completed relatively quickly. No additional funding is provided for this screening process[5]. The screen is also designed to identify those consumers who will meet the enrollment criteria because they qualify for existing programs, e.g., those enrolled or eligible for enrollment in community support programs for adults with serious and persistent mental illness or integrated service programs for children with severe emotional disturbance. The DHFS will require that the sites selected as demonstration sites cooperate with further development and testing of the screen.

The DHFS will prepare materials that county/tribal staff, or their subcontracted providers, must make available to all consumers. These materials will describe the prepaid, capitated component of the system of care. The MCO must administer a screen for any person who requests one after reviewing this information, even if the providers who know the consumer best do not think the consumer would meet the criteria for the prepaid, capitated component of the demonstration. The MCO must forward a copy of the completed screen, along with supporting documentation, to an independent reviewer that will be retained and paid by the DHFS. This independent reviewer will determine, based on the information forwarded by the MCO, whether or not the consumer is eligible for prepaid, capitated managed care. Consumers will have appeal rights if they are found not eligible.

The DHFS does not envision that individuals will be enrolled during times they are experiencing a crisis. Individuals presenting themselves to the MH/AODA system in crisis will have their immediate needs met by the service system using whatever funding is currently available (Medicaid, private insurance, county/tribal administered funding). Once the individual is out of risk of immediate danger to him or herself, or others,

[5] That is, no funding is available for the screening process once actual enrollment into prepaid, capitated managed care begins. As noted in Sec. IV some funding will be available to conduct screening prior to the capitated phase for rate-setting purposes.

and at such time as the individual can understand the information, enrollment information should be presented to the individual. The DHFS will develop further enrollment protocols in conjunction with the demonstration sites.

Capitation payments (pre-payment for services) will begin at the point that the consumer is enrolled in the prepaid component of the MCO.

After the consumer is enrolled in prepaid, capitated managed care, crisis services will be provided and paid through the capitated component.

2. Enrollment Choice

The consumer will have the opportunity to choose to be screened for the capitated component of the MCO, and if found eligible will have the opportunity to choose to enroll. The consumer may also choose to disenroll at any time. Furthermore, as addressed in the Bill of Rights and Responsibilities, the MCO may not disenroll the consumer unless the MCO has demonstrated just cause to the DHFS. Just cause is defined as a situation where continued enrollment would be harmful to the interests of the consumer or in which the MCO cannot provide the consumer with services for reasons beyond its control. The MCO will need to demonstrate that it has made reasonable, repeated efforts to serve the individual. Such requests for disenrollment must be approved by the DHFS.

3. Service Coordination

a. *Service Coordinator*[6]. Once a consumer chooses to enroll in prepaid, capitated managed care he or she must have a service coordinator. The MCO must provide the consumer with service coordinator choices. Ideally, this should consist of at least two distinct organizations offering service coordination. One of these options for adults may be a certified community support program (CSP) for those individuals who meet the standards for enrollment into a CSP. Within the service coordination agency, the consumer must also be afforded a choice of service coordinators.

b. *Initial Assessment and Plan of Care.* The service coordinator must develop an initial care plan upon first meeting with the consumer. Within 60 days, the service coordinator must complete a comprehensive strengths-based assessment (see draft in Attachment 12—the DHFS may make further modifications to the comprehensive assessment prior to finalizing contracts with the MCOs). For adults, this comprehensive assessment includes a consumer-completed questionnaire (Attachment 13). For children

[6] A service coordinator is another name for the person who is sometimes called the case manager or care manager.

and adolescents, the comprehensive assessment must include parent's preferences obtained through interviews (see Attachment 14[7]).

c. *Availability of choice*. Choice is a critical component of a recovery-oriented system of care. The availability of choice at every level of decision-making for consumers will be a measure of the degree to which the system is oriented towards the preferences and strengths of the consumer. The MCO must address the following types of choice for consumers:

(1) Consumer/Family participation in decision-making. The individual consumer must be encouraged to participate in the decision-making about what services the consumer or family receives in order to promote recovery. Even where the consumer is subject to some legal constraint (such as guardianship or commitment), the consumer should be as actively involved as their ability to participate permits.

(2) Choice of providers. The consumer should have a choice of options to meet their needs. To the maximum extent feasible, this should include a choice of individual providers of distinct services (e.g., psychotherapist, vocational counselor). Choice of an individual to prescribe medications is especially important. In order to meet this need where psychiatrists are not readily available, the MCO is encouraged to develop options such as the use of telemedicine, use of advanced practice nurse prescribers, nurse practitioners or primary care physicians with experience prescribing psychotropic medications.

The consumer should have the ability to change providers without cause at least one time per year. More frequent changes may be allowed with the agreement of the MCO or if the consumer demonstrates just cause to the DHFS.

(3) Choice of living arrangements. The consumer will have a choice of living arrangements, as identified in the Treatment and Recovery Plan of Care. The MCO should support the consumer to reside in the living arrangement of their choice. See sub. 5 for further description of MCO service provision requirements. The MCO is not obligated to pay for independent housing options (private house or apartment) if this is the consumer's choice, but would be expected to assist the consumer in achieving these housing goals.

[7] The DHFS is also working with representatives of the Aging Community to adapt the interview format for the elderly population.

(4) Informed consent. The MCO must obtain informed consent documentation from consumers, as appropriate, regarding the use of medication and participation in the treatment and recovery plan. See Attachment 3 for further information about informed consent.

(5) Informed choices. The MCO must provide consumers with sufficient information about their illness, medications, treatment alternatives, grievance procedures, consumer-operated services, community resources and advocacy organizations so that they can make informed choices. The DHFS will work with the MCO to identify information which needs to be provided to meet this requirement.

(6) Second consultation. HFS 94 Wis. Adm. Code gives consumers the right to receive a second consultation. Consumers retain this right to a second consultation when they enroll into prepaid, capitated managed care. Consumers enrolled in prepaid, capitated managed care also have a right to have the MCO pay for second consultations under the following circumstances:

- To ensure the completeness and the accuracy of the assessment and treatment and recovery plan of care.

- Reduce the risk of adverse outcomes for the consumer.

The DHFS will develop criteria identifying in further detail when the MCO must pay for a second consultation.

The MCO must inform the consumer of these rights.

The DHFS expects that the MCO will pay for consultation services as requested by the consumer and/or the treatment and recovery team as a matter of good clinical practice. The consumer would select a provider from among the MCO's provider network, unless the MCO does not have another appropriately qualified provider in their network. In this case, the consumer would be able to select a provider from outside the MCO's network. A provider from outside the network must be appropriately qualified to perform the consultation service and must be willing to accept payment on terms approved by the MCO.

If the MCO does not believe that the consumer's request for payment of the second consultation meets the DHFS criteria, the MCO must request a review by the DHFS

contract monitor. The contract monitor will provide an opinion within timeframes specified as part of the criteria.

Should the contract monitor find that the consumer's request does not meet the criteria, the consumer retains the right to file a formal grievance. Should the contract monitor find that the consumer's request does meet the criteria and the MCO refuses payment anyway, the consumer retains the right to file a formal grievance and the DHFS may take action as allowed under its contract with the MCO.

Although the DHFS supports the value of choice for consumers, nothing in this RFC alters any of the current statutes that might subject the consumer to involuntary actions (e.g., commitment, emergency detention, guardianship, adult protective services). However, as noted above, even when subject to involuntary actions, the consumer should be afforded whatever choice is still available to them in these situations.

4. Treatment and Recovery Plan of Care

Once the comprehensive assessment is completed the service coordinator must convene a meeting of the treatment and recovery team. This team consists of the consumer, the consumer's family members, any formal service providers the consumer may currently be involved with, and informal supports. Family members of adult consumers should be included as the consumer chooses, unless a family member has a legally defined relationship (e.g., guardian). For children, some family members must be included. Where a child is legally separated from his or her family of origin the determination about which adults to include should be based on the current legal status and the child's permanency plan. Informal supports include other relatives, friends, peers, and/or advocates as identified by the consumer and/or family. The service coordinator must document who the consumer has identified as informal supports and the service coordinator must also document their efforts to include these persons in the treatment and recovery team meetings.

The treatment and recovery team completes a treatment and recovery plan of care (POC) that is based on the comprehensive assessment (Attachment 15). Consistent with the recovery focus of the demonstrations, the POC must be highly individualized and reflect the desires and strengths of the consumer identified in the assessment. The team should always consider whether alternatives to professional services would be more appropriate and if not, how the team will determine when professional services can be reduced. The plan should identify the desired and recommended services and supports, who will provide these, when they will provide them, costs, if any, to the consumer, and anticipated measurable outcomes. The treatment and recovery plan should also address a plan for dealing with crisis situations. This plan should reflect the consumer's preference for

how they would like to be responded to during a crisis. Use of advanced directives for this purpose will be developed and encouraged during the demonstrations.

The DHFS envisions that the planning process will be highly collaborative, with each person bringing unique skills and perspective. Because the consumer is the expert on how the illness affects him or her and on his or her strengths, needs and goals, the consumer must have a strong voice on the team. Informal supports bring their knowledge of the consumer and their long-term commitment to him or her. Professionals bring their knowledge and skills with regard to the treatment of the illness.

In order for decision-making power to rest in the treatment and recovery team the service coordinator, as the representative of the MCO, must have authority to approve most plan of care recommendations. The DHFS envisions developing protocols that will guide this decision-making process and also serve as standards for appeals of denials or modifications of services. These criteria will be developed in conjunction with consumer and family representatives and the demonstration sites.

The treatment and recovery plan should be reviewed with the team at least every six months and more often if agreed upon when the plan is developed or if needed due to a change in the consumer's needs.

5. Service Provision Requirements

a. Medical Necessity for Medicaid-Covered Services

Medicaid covered services to Medicaid eligible individuals must be medically necessary. Services are considered medically necessary if they:

- ✓ Are identified on the treatment and recovery plan of care as approved by the members of the treatment and recovery team, and

- ✓ Also meet the medical necessary definition found in HFS 101 Wisconsin Administrative Code (see Attachment 16).

Since providers must meet all requirements for Medicaid-covered services, a physician's or psychologist's prescription or approval is needed prior to the delivery of a particular service, if a physician's or psychologist's prescription is required for Medicaid.

b. Clinically Indicated Services

All other services must be clinically indicated. Services are clinically indicated if they are identified on the treatment and

recovery plan of care as approved by the members of the treatment and recovery team.

While clinically indicated is a necessary criterion for MCO payment for a service or support, it is not sufficient. The MCO's obligation to pay for services is described further in the following sections.

Since providers must meet all applicable certification or licensure requirements a physician's or psychologist's prescription or approval is needed prior to the delivery of a particular service if a physician's or psychologist's prescription is required under certification or licensure for that service.

c. Service Authorization

Under the procedures described in III. D. 4, above, the DHFS envisions that most services will be authorized by the service coordinator during the treatment and recovery team meeting. MCOs do not have to use Wisconsin Medicaid prior authorization guidelines. However, for services that may require additional review, the MCO must approve, modify or deny services identified on the POC within the timeframes that will be established by the DHFS. Consumers have the right to appeal services that are modified or denied in accordance with the Consumer Bill of Rights and Responsibilities and Wisconsin Administrative Code. The MCO is strongly encouraged to utilize informal dispute resolution mechanisms that can address these issues in a timely fashion. The DHFS will develop some models that the MCO may wish to use.

d. Category A Services

Category A services are Medicaid-covered services. The MCO must make available all Category A services (as described in Attachment 17 for carve-in models and Attachment 18 for carve-out models) to Medicaid-eligible individuals, when the service is medically necessary unless the treatment and recovery plan of care identifies an alternative service which is preferable to the consumer. These services are an entitlement to Medicaid-eligible individuals. The MCO must use Medicaid-certified providers for Medicaid-covered services.

Category A services are not an entitlement for individuals who are not Medicaid-eligible. The appropriateness of any given Category A service for a non-Medicaid eligible individual is determined by the treatment and recovery plan of care. The MCO does not need to make every Category A service available to every non-Medicaid-eligible individual as long as it can provide services sufficient to meet the consumer's need in some other fashion.

e. Category B Services

Category B services represent the core services identified by the BRC in addition to levels of care recommended by the Wisconsin Uniform Placement Criteria (excluding those already identified as Category A services). Attachment 19 identifies the Category B services for enrollees in the prepaid managed care component of the demonstration project. The appropriateness of any given Category B service for any given individual is determined by the treatment and recovery plan of care. The MCO does not need to make every service available to every individual as long as it can provide services sufficient to meet the consumer's needs.

This listing is not meant to require the MCO to reimburse consumers for education or to participate in social activities (though this is an option if determined to be cost-effective). In areas not traditionally viewed as "treatment" the MCO's role is to work with the consumer to identify his goals and needs and how he will reach these.

Example: A consumer wishes to return to college to get his bachelor's degree (his studies having been interrupted by mental illness). The MCO would not be expected to pay the cost of college tuition. However, the MCO is expected to assist the consumer to identify what he would need to do to return to college and how he would accomplish these tasks. This may include:

- Referring a person to DVR.
- Saving or borrowing money; seeking a scholarship to pay cost.
- Redeveloping study habits.
- Helping the consumer identify how his mental illness symptoms might interfere with being successful in college and how this can be addressed.
- Identifying resources within the college to support or assist the consumer.

Example: A consumer is interested in joining a photography club but is uncomfortable with being in groups. The club has a small charge for some of its events. The consumer has an old camera but would like a newer one.

The MCO could address the discomfort in groups in a variety of ways: attending the club meeting with the consumer the first few times; having the consumer identify someone she knows who could attend with her; involving the consumer in an existing social skills development group. The MCO could help the consumer

identify how to find money for the club. Or, if the MCO has a member account, it may agree to loan the consumer money for a predetermined number of meetings so that the consumer can decide if this is something she wants to continue doing, at which time the consumer would take responsibility for paying. The MCO can help the consumer explore ways to obtain a better camera.

f. Category C Services

Category C services are other services, not already identified, that are recommended by the treatment and recovery team to meet the needs of the consumer. The ability to provide Category C services is a key component of the demonstrations, as it acknowledges the need for individualized, consumer-focused responses to persons in need of mental health and AODA services. However, because these services cannot be specified or itemized in advance they are most likely to be the subject of dispute between the MCO and the treatment and recovery team and/or consumer. The MCO is strongly encouraged to utilize the informal dispute resolution procedures to address these disputes. While the denial of specific service or supports that would fall into Category C cannot be appealed through fair hearing, the consumer may file a contractual complaint if he or she does not feel that his or her treatment and recovery-related needs are being met by the MCO.

Some examples of Category C services might be:

- Alternative vocational opportunities.
- Adaptation of home environment.
- Therapeutic recreation.
- Rent assistance.

g. Waiting Lists

Once a consumer is enrolled in prepaid, capitated managed care, the MCO may not maintain waiting lists for services. The MCO must provide services sufficient to meet the consumer's needs. Since the MCO is not mandated to have all Category B services, the MCO may have policies identifying under what conditions it will make these Category B services available. However, if a particular Category B service is not currently available, the MCO must work with the treatment and recovery team to identify ways to meet the consumer's immediate needs.

When the treatment and recovery team recommends a Category C service, the MCO is not required to make that service available

immediately, if it would be unreasonable to expect the MCO to do so. The MCO should utilize its Quality Improvement process to identify Category C services that are frequently recommended and develop plans to implement these options.

Example: An MCO finds that many of its children and adolescents require short-term residential treatment to stabilize individuals with aggressive behaviors while they begin to work with the family on managing the child in the home. However, currently there are no such programs available within a reasonable geographic distance. The MCO can begin a process to procure such services and work with willing providers to develop this option.

At the individual level, the treatment and recovery plan should identify a plan to make preferred options available. The consumer, family, treatment team and the MCO must be mutually responsible for both meeting the consumer's needs and recognizing the increased fiscal responsibility of the MCO. Use of high cost services reduces the availability of options for other consumers. *Example:* An adult consumer wishes to move out of his parents' home into independent living. At the current time the consumer does not have the daily living skills necessary to live in an unsupervised apartment. While a group home would meet the consumer's immediate need, the MCO would not be required to make this option available to the consumer if the MCO did not have capacity in its group homes. However, the MCO may develop a plan to identify the skills that the consumer needs to live independently and begin to work with the consumer on developing these skills while the consumer continues to live with his or her parents. The consumer may be offered services at an existing clubhouse that will assist in this skill development. The MCO would also work with the consumer (and the family, with the consumer's consent) to identify the cost of independent housing, the type of housing preferred, the area preferred, etc., so that the consumer can start to identify potential independent living options.

Note, however, that in an emergency situation, such as the unexpected death of the consumer's parents, the MCO might need to provide a supervised housing option immediately until such time as the consumer can live independently.

h. Court-ordered Services

The MCO must provide any medically necessary or clinically indicated court-ordered placements or services from Category A or Category B unless the court orders a provider not in the MCO's provider network and the MCO could have provided the service through their own network. Court-ordered placements or services would include, but are not be limited to, those related to Chapter

48, Chapter 51, Chapter 55 or services required as part of a driver safety plan.

i. Enrollment Limits

Although the MCO must meet the needs of those consumers it enrolls into the capitated portion of the MCO, and may not maintain waiting lists for those individuals, it may establish a limit on the number of people it will enroll into prepaid, capitated managed care. The purpose of this limit is to ensure that the MCO is able to meet the needs of all the enrollees. The MCO will identify any limits it may wish to establish on the capitated component of the organization (this limit may be renegotiated during the contract term). The MCO may establish separate limits for Medicaid and non-Medicaid eligible individuals, but the limit for non-Medicaid eligible individuals may not be less than 25 percent of total expected enrollment. The DHFS expects the MCO to expand this limit over time as it develops the capacity to serve additional consumers.

j. Emergency Services

The MCO must have emergency services available 24 hours a day, 7 days a week and be able to respond to requests for emergency services within 30 minutes. Because mental health crisis intervention is a Medicaid-covered service, all MCOs must have a Medicaid-certified crisis intervention program as part of their network. The MCO need not have a certified program at the time they submit their proposal, but must document that they are in the process of seeking certification.

Carve-out programs must provide services for psychiatric or AODA emergencies:

- A psychiatric emergency is a situation involving significant risk of serious harm to the consumer or to another person due to the consumer's actions.

- An AODA emergency exists if there is a significant risk of serious harm to the consumer or if there is a likelihood of return to substance abuse without immediate treatment.

Carve in programs include the above and must also be able to address emergency medical conditions:

- An emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of

health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1) Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

2) Serious impairment of bodily functions, or

3) Serious dysfunction of any bodily organ or part.

k. Uniform Placement Criteria for Substance Abuse

The MCO must utilize the Wisconsin-Uniform Placement Criteria, ASAM or similar placement criteria that have been approved by the department, in order to determine the appropriate level of care for individuals in need of substance abuse services. All levels of care identified in the placement criteria are considered either category A or category B services under the contract.

l. Dual Diagnosis Services

Integration of mental health services with substance abuse services is a primary goal of the demonstration projects. Current funding constraints often make it difficult to provide the most effective types of integrated treatment for persons who are dually diagnosed. The MCO must identify how it will improve integration of services for this significant portion of the population.

Generally, these improvements will take one of three forms:

- Cross-Training of Staff. Training on MH issues is made available to AODA professionals and training on AODA issues is made available to MH professionals. The goal of cross-training is to improve the ability of current program staff to treat persons with dual diagnosis within current treatment settings. For instance, staff in a mental health day treatment program can better recognize and respond to AODA issues in their program clients.

- Co-locating Staff. MH professionals are located in AODA programs and AODA professionals are located in MH programs. This enhances the ability of the program to provide treatment of both disorders in the same program. The co-located professional also provides cross-training to the professionals from the other discipline. For instance, an AODA professional co-located at a MH day treatment program can provide AODA education and treatment groups.

- Developing New Services Especially for Persons with Dual Diagnosis. Rather than enhancing existing programs, the MCO develops a new service, or set of services, that is especially designed for persons who are dually diagnosed. The services contain a mixture of MH and AODA professionals and are geared to address the unique issues of this population (e.g., AA groups that are sensitive to the need to take psychiatric medications).

The goal of any of these approaches is to enhance the continuity of treatment. Too often in the current system consumers need to attend separate programs at separate times to have their treatment needs addressed. A portion of the start-up funds may be used to meet this requirement and should be identified in the project budget in Sec. VIII.

m. Primary and Acute Care

Medicaid-covered primary and acute care services are a Category A service for Medicaid-eligible individuals enrolled in carve-in (integrated) programs. For non-Medicaid eligible individuals in carve-in programs and for all enrollees in carve-out programs, the MCO must address the primary and acute care needs as part of the treatment and recovery plan of care. Although the MCO is not responsible to pay for these services, the MCO should use their service coordinators to assist the consumer to gain access to primary and acute care services identified on the treatment and recovery plan.

n. Program Standards

As noted in sub. d, above, the MCO must use Medicaid-certified providers for Medicaid-covered services. Similarly, the MCO must use state-certified or licensed providers for any services that are regulated by the State.

The DHFS recognizes that it may be at times contradictory to seek increased flexibility through the demonstration projects, while continuing to hold people to fixed program standards. Program standards have been a proxy for quality in the absence of the type of outcome based system we hope to create. However, during the period where we are still implementing and perfecting a new approach, many stakeholders may be reluctant to move too far from these existing standards.

The DHFS currently has the authority to waive many elements of program standards. In the context of the demonstration projects, the DHFS will attempt to facilitate waivers under this existing authority, including HFS 106.13, as long as the demonstration sites can demonstrate how the intent of the standards continues to be addressed. Proposers must identify in their proposals the standards they wish to have waived, the rationale for the requested waiver and how they will ensure the health and safety of consumers and quality of services. The DHFS, in consultation with the BRC-IAC (or a subcommittee of the BRC-IAC), will evaluate these waivers, consistent with the requirements for waivers already contained in administrative code.

In addition to specific program standards, the DHFS will review more general administrative requirements contained in HFS 1 as they impact the demonstrations. Certain existing requirements for purchase of service, fee schedules, etc., may not be consistent with the manner in which managed care entities operate.

E. Consumer and Family Involvement Requirements

Consumer and family involvement is critical to the goals of the demonstration projects. This involvement must occur at multiple levels. The system of care envisioned in this RFC is a partnership among consumers, family members, providers, county administrators and other community stakeholders.

1. *Consumer and Family Members' Role in Governance*. Consumers and family members must have a strong role in governance and oversight. The standard proposed by the Recovery and Consumer/Family Involvement Workgroup was to have no less than one-third of the governing board comprised of consumers and family members (and that these be balanced to represent both MH and AODA and children/ adolescents, adults, and elderly). However, the DHFS recognizes that at this stage of development the board with true fiscal and programmatic authority and accountability will be the human services board or the county/tribal board. Because membership on these boards is constrained by current regulations, meeting the one-third requirement on these boards will be difficult, if not impossible. However, the MCO will be expected to identify ways to ensure that consumers and family members have legitimate voice in the governance of the MCO, such as a consumer advisory board. Consumers involved on governing boards may be persons who:

   - meet or would likely have met the criteria for BRC target populations 1 and 2 during the time they were receiving services, or

   - have a substance abuse disorder, with or without a co-occurring mental illness, that has resulted in a level of functional impairment similar to that which defines an individual in BRC target populations 1 and 2.

   Family members are parents, foster parents, spouses, siblings, children or significant others of persons who meet the definition of consumers above.

2. *Consumer and Family Representation on Quality Improvement Committee*. The MCO will be required to have consumers and family members on their internal Quality Improvement Committee. The MCO must choose from prospective candidates nominated by local consumer and family groups. The MCO must try to balance representation of mental health and AODA consumers as well as family members of children, adults and elderly.

The MCO may also identify other ways for consumers and family members to provide input to the QI process (e.g., surveys, focus groups). Irrespective of the method of obtaining input, the MCO must document the input received, the MCO's response to the input (such as changes in policies, procedures or services available, or studies implemented as a result of the feedback) and how feedback was provided to enrollees about the input and responses to the input.

3. *Consumer Affairs.* The MCO must provide the following functions aimed at helping consumers and families get what they need:

- Provide outreach to consumers and families.
- Be a liaison to the consumer community to identify gaps in services and obtain input on program quality.
- Develop recommendations on issues that may be identified through the Quality Improvement process (e.g., use of seclusion and restraints, adequacy of culturally sensitive providers).
- Work with the MCO to develop solutions to identified problems.
- Provide advocacy for consumers and families.
- Develop a network of peer support individuals/groups that will be available to consumers.
- Provide information about services and supports available about general mental health or substance abuse issues.
- Attend town hall meetings.
- Identifying and implementing strategies that help fight stigma.
- Identify additional ways the MCO can involve consumers and family members in their operations.

The MCO is strongly encouraged to have a consumer or family member carry out these activities. The person in this position should have considerable latitude in their overall involvement within the MCO.

4. *Other Requirements Related to Consumer and Family Involvement*:

- The MCO must include consumers and families as part of the selection process for service providing agencies and service providers. This may involve providing input on past experiences with providers or agencies, identifying the characteristics or qualifications consumers prefer in provider staff or participating on review panels.

- The MCO must identify other ways it will involve consumers and family members in the operations of the organization. Examples included:

    - Contracting with a consumer satisfaction team to obtain data on consumer assessment of program quality.

    - Hiring consumers and family members at any level of the organization (e.g., administrative staff, direct service staff).

F. Recovery-Oriented System Requirements

1. *Consumer autonomy*. All services and supports offered by the MCO must promote consumer autonomy and community reintegration and build on consumer-identified strengths and goals.

2. *Maintenance of services*. The MCO must ensure that individuals in the capitated component of the MCO continue to receive services according to their individualized treatment and recovery plan. The MCO may not disenroll the consumer from the capitated portion of the MCO solely because the consumer is receiving no formal services. The MCO must be able to increase formal services in a timely manner to address any increase in service needs.

3. *Recovery strategies*. The MCO must implement strategies for recovery in the following areas:

    - Developing consumer/provider partnerships that promote the concepts of recovery.

    - Encouraging the use of natural supports and community resources.

    - Strengths-based planning.

    - Individualized services and supports.

    - Consumer choice.

    The DHFS will take the lead in developing a "Strategies for Recovery" workplan. The MCO will be expected to participate in this process following their selection as a demonstration site.

4. *Consumer Operated Programs*. The MCO in its proposal is required to identify whether and how it will contract with consumer operated services. The DHFS will offer consultation to develop a plan for promoting the use of consumer operated services.

5. *Recovery Training*. The MCO must provide or arrange for recovery training for all individuals providing services under this contract (both in the capitated and non-capitated component) within two years from the date

the MCO begins enrolling individuals into prepaid, capitated managed care. The training is not limited to clinical personnel, but must also include other staff who, by the nature of their jobs, have regular contact with consumers. This would include receptionists and clerical staff who may need to interact with consumers in obtaining information for the clinical record. In residential facilities this might also include janitorial or maintenance staff who regularly work in the residence when consumers are present.

The DHFS will develop core training modules for consumers, families, professional, and mental health administrators which will be tied to specific outcome expectations. The DHFS will also provide recovery training in conjunction with DHFS-sponsored conferences and events, when feasible, in order to support this training requirement.

G. Quality Improvement

1. Overview

Quality improvement (QI) is a critical aspect of managed care. The move from a fee-for-service environment, where a consumer may move from one provider to another, to a managed care environment, where the MCO is accountable for the care of the consumer, adds a number of requirements to the MCO's operations.

Additionally, this is an area of considerable change and development within the Medicaid program. The Balanced Budget Act (BBA) of 1997 considerably increased the requirements in the area of QI. Demonstration sites will be required to meet all requirements from the BBA that are applicable to these programs. See attached I-Care contract for current requirements.

Proposers can access current information about these regulations through HCFA's website at www.hcfa.gov. These regulations require the MCO to have standards for:

- Access and availability of services/providers.
- Adequate provider network for all services.
- Credentialing of providers/practitioners.
- Coordination and continuity of care.
- Utilization management criteria and procedures.
- Enrollee rights, information and confidentiality.
- Practice guidelines or "best practices."

- Enrollment and disenrollment rules.

- Grievance and appeals process.

In addition, the MCO must:

- Achieve minimum performance in clinical and non-clinical areas specified by the State using standard measures.

- Have mechanisms to detect over and under utilization.

- Engage in performance improvement projects as defined by the state contract.

- Participate in at least one annual statewide quality improvement project.

- Base performance assessment on valid, reliable data.

- Annually evaluate the effectiveness of the QI program or submit to annual review by the State.

- Achieve significant and sustained improvement over time.

The DHFS intends to work with the selected demonstration sites on a plan to reasonably achieve these requirements over a three-year period beginning at the point when start-up funds become available.

2. Activities to Date

A number of activities in our planning support the ability of the DHFS and the MCOs to meet these QI requirements:

a. *Consumer Outcomes.* The DHFS convened a group to work on consumer outcomes in December 1997. The DHFS contracted with Dr. Joy Newmann, Associate Professor of Social Work at the UW-Madison, to provide technical consultation and assist in developing a consumer survey. This survey will measure consumer perceptions of their access to care, the quality and appropriateness of care and the outcomes of their care. The workgroup has also identified a number of existing tools that providers can use to assess clinical and functional outcomes of care. This survey focuses on adults and elderly.

The workgroup based their efforts on the consumer outcomes identified by the BRC (see Attachment 20). The survey will attempt to measure consumer outcomes in all 15 domains, unless it is determined that certain outcomes can be better measured through data other than a consumer survey.

The DHFS plans to have this survey conducted through an entity other than the MCO. A sample of consumers from each MCO, and possibly a group of persons in counties/tribes not part of the demonstrations, will be surveyed. The DHFS will make aggregate results available to the MCOs and the public.

b. *Performance Indicators.* The Quality Improvement workgroup has recommended a number of performance indicators that will be collected directly from the MCO (see Attachment 21). These indicators represent both clinical and non-clinical areas of performance. These indicators, along with the consumer survey, will assist the state and the MCOs to meet the QI requirements noted in the previous section, including federal Medicaid requirements. They were also selected with an eye towards supporting the performance improvement projects required by HCFA. Finally, note that a number of these indicators represent information currently being collected for the Human Services Reporting System (or are part of the MH module consumer status data set which is projected for implementation for all counties in July 2000), so do not represent new requirements for the county/tribe.

The list in attachment 21 does not represent a final list of indicators. The QI workgroup is still reviewing other possible indicators. The DHFS will develop a final list that will be reviewed and discussed with the demonstration sites once they are selected.

c. *Enrollee Rights.* The Consumer Bill of Rights and Responsibilities has been addressed previously (see Attachment 3). This document also addresses the grievance, appeal or fair hearing processes associated with these rights.

d. *Prevention/Early Intervention.* Preventative care objectives are an important aspect of a QI program and one that is required under the Balanced Budget Act. Successful prevention efforts can decrease the demand for treatment. While prevention has been an integral part of the AODA services continuum, and a significant portion of the substance abuse block grant must be spent on prevention, mental health is lagging behind in prevention initiatives.

The BRC identified three mental disorders proven to respond to prevention efforts:

- ✓ Conduct disorder in kids.
- ✓ Depression in all ages.
- ✓ Post Traumatic Stress Disorder in all ages.

The Prevention/Early Intervention Workgroup has recommended that the MCO address at least one of the priority at-risk groups:

- ✓ Victims of abuse, trauma and violence.
- ✓ At-risk pregnant and postpartum women.
- ✓ Low birth weight infants and those born to at-risk mothers.
- ✓ Children in foster care/out of home placement.
- ✓ Children with family members who have mental illness.
- ✓ Children with family members who are incarcerated.
- ✓ Children with family members who are substance abusers.
- ✓ At-risk youth and their families.
- ✓ Older adults experiencing multiple risk factors or losses such as loss of health or loss of a spouse.

The MCO must develop a plan for addressing prevention activities for one of these groups as part of its initial quality improvement workplan. Identification of the priority group should be made in collaboration with other agencies that might be serving the same or similar populations and should be based on an assessment of the needs of the community served by the MCO. The DHFS will provide technical assistance on research-based prevention activities and on the characteristics of an acceptable prevention plan (e.g., identifying measurable outcomes, appropriate evaluation methodologies). These prevention activities will be phased in during the demonstration period.

3. Practice Guidelines

The BBA requires that MCOs develop or adopt existing practice guidelines. The DHFS will provide technical assistance to the demonstration sites on requirements for practice guidelines.

4. Project Evaluation

The DHFS intends to evaluate the demonstrations to determine whether they have accomplished the goals described in Part I. Information gathered through the QI activities noted above would be used for this evaluation. As evaluation planning continues, the DHFS may identify other information needs. The DHFS expects the demonstration sites to work in good faith to provide information needed to conduct an evaluation of the project.

5. Initial Requirements for the MCO

The DHFS anticipates that during the first 18 months after being selected as a demonstration site, the MCO will need to accomplish the following:

- Develop an organizational mission and strategic plan for QI.
- Designate a management leader whose function is to secure needed resources and support the program.
- Develop the operational framework for implementing required QI elements.
- Create an initial coordinating structure.
- Define the QI purpose and structure within the organization.
- Define the role of the MCO versus service providers versus consumer/families in the QI process.
- Create linkages with other MCO management activities, (e.g., grievances, provider services, resource allocation, etc.).

- Identify opportunities for consumer and family involvement.

- Recruit participation from a cross-section of providers, consumers, families, and staff.

- Complete a baseline self-assessment survey to assess current capacity to meet the contract standards.

- Develop a workplan that details specific activities to achieve compliance with QI contract standards.

    - ✓ specifies time frames and identifies responsible parties for each activity

    - ✓ includes a process for annual evaluation of how the implementation strategy is working and for making necessary changes

    - ✓ includes an analysis of current resources and a plan for securing additional resources for future QI functions and activities

    - ✓ identifies how consumers and families will be involved, including how they will be provided training to support their involvement

The DHFS, through meetings with staff from the demonstration sites, will:

- educate you on the scope of the requirements.

- assist you in determining how you will set priorities for the future.

- determine how we can assist you in meeting the requirements in the future.

H. Administrative Requirements

1. Solvency Protection

a. Carve Out Programs

Counties and tribes proposing to offer MH/AODA services only through capitation do not need to be licensed by the Office of the Commissioner of Insurance (OCI) as long as they are not subcontracting risk to any private providers (see sub c. below). See Sec. V. B. 4, for additional information about solvency requirements.

Counties and tribes will be required to submit quarterly financial summaries of revenues and expenditures to the DHFS. The DHFS and the county/tribe will review these financial summaries to determine whether potential solvency problems are evidenced.

b. Integrated Programs

Only licensed health maintenance organizations may assume risk for the range of Medicaid primary and acute care services. This licensure requires specified solvency protections. Counties and tribes may contract directly with the DHFS for the entire Medicaid services capitation and then subcontract the primary and acute care services, along with the risk for these services, to a licensed HMO.

The OCI has jurisdiction over licensure of HMOs and counties/ tribes are encouraged to contact OCI if they have questions about potential contracts.

The subcontract between the two entities is subject to review and approval by the DHFS. The DHFS is most interested in integrated models that include functional integration of service delivery and some mechanisms for sharing savings between MH/ AODA services and primary and acute care.

c. Subcontracting Risk to Other Private Providers

If the county/tribe subcontracts part or all of the administrative or service components of the program to a private provider, and in doing so puts the subcontractor at financial risk, that subcontractor falls under the jurisdiction of the OCI. If the subcontract is for the MH/AODA services only, or some subset of these services, the private provider will need to be licensed as a limited services health organization. The county/tribe is encouraged to contact OCI if it is considering such an arrangement.

2. Management Information System (MIS) and Reporting Requirements.

a. Management Information System Capabilities

MCOs must have the ability to collect and analyze data on utilization, expenditures, progress in treatment, outcomes, and other information on a client by client and aggregated basis in real time. This requires an MIS system that is integrated across program areas, is relational and programmable. The DHFS will not require the MCO to utilize a particular product. However, any MIS must be able to accomplish, at a minimum, the following tasks:

- Maintain a client database for all county 51 clients that can identify which clients are enrolled in the capitated component of the program, their Medicaid ID numbers, county of residence, enrollment start and end dates (with the ability to record multiple enrollment episodes), and service specific utilization and expenditures by client.

- Track the allocation of the capitated payments to Medicaid-eligible individuals. The MIS must have the capability of reporting the use of these funds by service type (e.g., inpatient, outpatient, day treatment) and whether the service was primarily for MH or AODA treatment or both. (These requirements are to support potential risk-sharing activities, as described in Sec. V. B. 5. These requirements may change as DHFS and the demo sites make final decisions on risk.)

- Track the allocation of non-Medicaid dollars for both Medicaid recipients and non-Medicaid recipients by consumer, by service provided.

- Record and report required clinical information (to be specified).

- Record and report performance indicators (see section III.G.2.b).

- Unless the MCO decides to contract for claims processing, have the ability to conduct claims processing and payment, maintain information on expenses incurred but not yet reported, collect and report third party payments and have the ability to report on the time to process clean claims.

- Maintain clinical and functional data to support QI activities such as provider profiling and focus studies.

- Maintain data on complaints and grievances, including complaints by type, time to resolve, and result.

- Maintain data on services requested, authorized, provided or denied.

- Incorporate Medicaid enrollment information from the fiscal agent.

- Provide encounter data, with elements specified by DHFS (see Attachment 22) for the encounter data set approved for the Medicaid HMO program. While this exact set may not be required for this demonstration project, the DHFS will want to collect comparable data).

Counties and tribes will retain the requirement for HSRS reporting. The DHFS believes it would make sense for this function to be integrated into the same MIS. The DHFS will use data reported to HSRS, when possible, in lieu of requiring reporting by the MCO.

b. HIPAA Requirements

All reporting will have to conform to the requirements of the Health Insurance Portability and Accountability Act (HIPAA). Current information on HIPAA is found in Attachment 23.

c. Timeline for MIS Capabilities

The DHFS anticipates that at the time demonstration sites are selected we will have identified fairly detailed descriptions of the data elements that the MCO must be able to collect and report and any other tasks the MCO must be able to accomplish with their MIS. Workshops will be scheduled for July – December 2000 with the demo sites and alternates to review these specifications and make modifications as necessary. See Sec. VI. for further information on the implementation tasks. The DHFS expects the first demonstration sites (those receiving start-up funds in July 2000) to have their MIS system fully operational by January 2002 in order that enrollment into prepaid, capitated managed care may begin by this time. Similarly, the second demonstration sites are expected to have a fully operational MIS by July 2002, having received initial start-up funding in January 2001. A portion of start-up funds may be used to develop the MIS system. This needs to be identified in the program budget in Sec. VIII.

d. Reporting Expectations

The DHFS will require reports of both programmatic and fiscal activity for the purpose of documenting that the MCO is meeting project objectives. These reports will be specified in the contract between the MCO and the DHFS. If the MCO fails to accept these

obligations the DHFS may choose not to enter into a contract with the MCO.

IV. RESOURCES AVAILABLE

The 1999-2001 biennial budget allocated $160,000 each for start-up funding for the demonstration sites. The funds will be payable in two equal installments—one when the initial contract for start-up funds is signed and one six months later. Initial funding for the first two demonstration sites will be available on July 1, 2000. Initial funding for the second two demonstration sites will be available on January 1, 2001. Note that the start-up funds allocated in the 1999-2001 budget only cover the first installment of start-up funds for the second two sites. The remainder of the start-up funds will need to be allocated in the 2001-2003 biennial budget. Availability of these funds will be dependent upon passage of that budget.

The DHFS anticipates that start-up funds will be made available through an addendum to the state-county contract and that payments will be made through the CARS system.

The following are allowable uses for the start-up funds:

- Costs of staff person needed to develop MCO policies and procedures, develop provider network and contracts and other functions necessary to prepare for enrollment.

- Costs of the purchase and development of management information systems.

- Specialized programming for co-occurring mental illness and substance abuse.

- Costs of a consumer affairs coordinator or other activities to develop or enhance consumer operated programs.

- Costs related to quality assurance activities for the demonstration project.

- Costs related to increasing consumer and family involvement in planning, decision-making and evaluation of local demonstrations.

The proposer must identify how they will use these funds on their budget worksheet. Funds cannot be used to supplant current salaries.

The DHFS is currently in the process of exploring with HCFA the degree to which we can obtain federal Medicaid administrative funding to support these start-up activities. If the allowable uses of these funds is effected by these discussions, or if we determine that additional funds will be available to the demonstration sites, we will inform those counties/tribes that return a letter of intent to submit a proposal.

In addition to the resources contained in the budget, the DHFS will seek to prioritize any discretionary funds to support the demonstration projects. This will include new block grant funds where the DHFS has the authority to target the funds to individual projects.

It is also the intention of the DHFS to apply for a grant to assist in the implementation and evaluation of the project. The DHFS will seek to obtain funds through any such

grant to support the demonstrations, especially in those areas where the demonstrations are seeking to develop new service options (e.g., prevention/early intervention).

V. PAYMENT

A. Payment

1. Overview

The DHFS, in collaboration with our planning partners, spent a considerable amount of time attempting to identify costs associated with serving individuals in the target populations for the demonstrations. This process has yielded a considerable amount of illustrative data, which will be described in a following section. However, the limitations of the process and remaining questions about the adequacy of the resulting data have led us to believe that it would be inappropriate to project payment rates for the demonstration projects at this time. In the following sections we will describe the process we used to attempt to identify payment rates for the demonstrations, the data we developed through this process, the data limitations and the proposal for moving towards a determination of payment rates once the demonstration sites are selected.

2. The Rate-Setting Process

In typical Medicaid managed care programs, Medicaid eligible individuals are identified for inclusion based on what are known as "medical status codes." The terminology may be confusing because the codes do not relate to a person's medical condition or functional status. These codes describe the way in which the individual became eligible for Medicaid, e.g., as a recipient of (Aid to Families with Dependent Children) AFDC, as a person who receives Supplemental Security Income (SSI), as a child in foster care, etc. When using these codes, it is a fairly simple and straightforward process to identify all individuals eligible to enroll, and correspondingly, to identify their utilization and costs for services.

However, the eligibility criteria for MH/AODA managed care, as is the case for some of our other managed care programs for special populations, is based on functional criteria. We cannot identify these individuals in a straightforward way using Medicaid claims and eligibility data alone. As a result, we worked with our planning partners to attempt to identify a cohort of individuals presumed to meet the functional criteria for the demonstrations.

Our first step in this process was to compile a database identifying a group of individuals believed to be functionally eligible for the demonstrations based on certain criteria applied to Medicaid claims data and the HSRS database. These databases are described in Attachment 24.

Next, we shared these databases with our county planning partners. Using decision rules developed by the workgroup (see Attachment 25 for a list of these decision rules), the county planning partner staff identified whether individuals were known to them or not and, if known, whether they believed they met the target population criteria.

Because there were a large number of "unknowns" after the planning partners completed their review, the DHFS then used additional criteria for assigning individuals to the database of individuals believed to be eligible for the demonstrations. These criteria are described in Attachment 26.

Using this population database, the DHFS-contracted data consultants extracted Medicaid claims data to develop utilization and expenditure tables for each of the planning partner counties/sites. The rate-setting workgroup members reviewed these tables for reasonableness. Based on this review, further data work was conducted to address data concerns identified by the planning partners. Once these concerns were addressed, the database (see Addendum 2 for further information about the partner county database) was forwarded to the Medicaid-contracted actuarial firm of Milliman and Robertson (M & R). M & R has been consulting on this project since the inception of the rate-setting workgroup in June 1998.

3. The Actuarial Analysis

M & R conducted an actuarial analysis of the data. This analysis is presented in Addendum 1. Because of time constraints, this analysis includes MH/AODA services only (including pharmaceuticals).

This analysis, as M & R point out, should only be used as a "benchmark" for counties and tribes, as they decide whether participation as a demonstration site might be financially viable. Because the analysis was done on partner county data only, it may not reflect actual fee-for-service equivalent (FFSE) costs for persons in other counties/tribes. Potential proposers should note both the similarities and the differences in FFSE cost data across sites, as well as the similarities and differences based on age, gender, and medical status code.

FFSE cost data for non-partner counties is included in Addendum 2. While this data has not gone through the same type of analysis as the partner county data, it does incorporate what we learned from the planning process to select as best we can a functionally equivalent group. The specifications for selecting the proxy group are found in Attachment 27. This data may help non-partner counties and tribes to determine how their costs may vary from those of the partner counties.

4. Limitations to the Data

A number of important limitations identified in the actuarial analysis bear emphasis:

- The information presented represents projected FFSE costs for individuals in the target population for CY 2001, the year we originally projected that capitated payment would begin. This represents the estimated costs for these individuals if they remained in the Medicaid fee-for-service system. Federal Medicaid regulations require that we pay no more under managed care than we would pay under fee-for-service for the population eligible to enroll in managed care.

- There are a number of adjustments that must be made to the FFSE costs that will effect the final capitation rate:

  - *Discount*: The discount is the percent by which the FFSE is reduced in order to generate savings to the State and in order to ensure that we meet the requirement of not spending more under managed care than we would under FFS. (See Sec. B, 1, below, for additional discussion of this issue.)

  - *Administrative Adjustment*: The administrative adjustment is an add-on to the FFSE costs to account for savings to the Medicaid program in reduced administrative costs. For instance, since the MCO will be responsible for service authorization decisions, Medicaid costs related to prior authorization of services are reduced. Also, since Medicaid makes only a single monthly payment, it saves on claims processing costs (since most individuals will have multiple claims on their behalf during a given month).

  - *Intergovernmental Transfers*: Costs related to intergovernmental transfer programs were not included in the claims database. For instance, counties and tribes that received payment under the Community Services Deficit Reduction Benefit (CSDRB) did not have these payments included in the expenditure data if identified individuals utilized services covered under CSDRB.

- *Other Non-Claim Transactions:* Other transactions, such as recoupments or one time payments that were not made through the claims system (or were not captured on the system at the time these claims were retrieved due to a delay between a service date and a recoupment) were not included.

- There were a significant number of individuals who were believed to be Medicaid eligible but for whom either a positive match to Medicaid eligibility could not be established (due to missing or incomplete data) or for whom no Medicaid claims were found. Inclusion of these individuals would change these FFSE costs.

- Although claims data was collected for three years (1995-1997), there were significant differences in the data from 1995 that caused the actuaries to exclude this data from their analysis. As a result, their development of FFSE costs is based on two years data, rather than three years that we prefer to use.

- The trend rate was developed from the middle of the base period (January 1, 1997) to the middle of the first demonstration year (July 1, 2001). This is a longer period than we generally use to trend data forward. The further ahead we must project trends, the more likely it is that new factors will arise that affect the accuracy of these trends.

- A large percentage of the individuals identified in this analysis had yearly Medicaid claims under $1,000—in some cases up to 60 percent. Since individuals eligible for the demonstrations are defined to be people with considerable service needs, this data was of some concern. While these low Medicaid costs can be accounted for in a variety of ways (recognizing that counties/ tribes are providing services from funds they administer), we cannot rule out the possibility that the process did not correctly identify individuals who were included in the population database for analysis. It is important to note, that these "low-cost" individuals cannot be accounted for based on those individuals that DHFS included from the persons counties/tribes identified as "unknowns" to them. According to M & R, there were not significant differences between the costs of these persons and the costs of persons positively identified by the planning partners.

5. Moving Towards Capitation

As a result of the concerns about the actuarial analysis the DHFS, in consultation with the BRC-IAC, has decided upon the following approach to moving towards capitation after the demonstration sites have been selected:

- Extend the period between when start-up funds are available and when people are enrolled into prepaid, capitated managed care to 18 months. For the first demonstration sites this will be the period from July 1, 2000, to January 1, 2002.

- During this period undertake an extensive screening effort to positively identify persons who might be eligible for enrollment. We will use the functional screen developed by the planning partner workgroup on screening and enrollment (with any modifications that may be made during field testing). We will attempt to screen a broad cross section of individuals, both individuals served through the county/tribe and those on Medicaid who may not currently be served by the county/tribe.

- Analyze historical Medicaid claims data on these individuals for purposes of setting capitation rates.

- Work with the demo sites to estimate as best we can the community aids and tax levy dollars supporting these individuals.

- Work with demonstration sites to ensure they are accurately billing for all Medicaid services they currently provide so that this data can be factored into the rate-setting. To the degree that demonstration sites are implementing newer Medicaid benefits (AODA residential, Comprehensive Community Services) we will attempt to identify how these service costs can be incorporated into the capitation rate.

Although this process delays implementation of capitated managed care, and the flexibility in Medicaid funds that this brings, we believe that it will result in a payment structure that both counties/tribes and the DHFS will be more comfortable with.

6. County Share

Although the DHFS intends to capitate Medicaid funds only at the time the demonstrations first go to capitation, one goal of the project is to ensure that these funds are integrated with the funds counties and tribes now administer to serve the target populations. Therefore, it is important to be able to identify utilization and expenditure of county/tribal administered funds for the target population.

We worked with our planning partners to identify the degree to which they could produce data similar to that we produced for Medicaid expenditures. For a variety of reasons, counties and tribes are not currently able to produce consumer specific utilization and expenditures across all services and by funding source. Our planning partners were able to identify only an approximate aggregate "cost" to serve members of the target population. (Note: since the planning partners identified aggregate "costs" these numbers do not tell us what portion of these costs were covered by Medicaid revenue, community aids, other third party payments or county tax levy.)

The limited specificity of this data is problematic for a number of reasons:

- Without a clear identification of the costs associated with members of the target populations, counties/tribes will not know how to budget funds to the demonstration projects.

- Without a benchmark of current expenditures we will not be able to demonstrate whether costs under the demonstrations have increased, decreased or stayed the same.

- Without a clear, verifiable delineation of these funds, the ability to enter into risk-sharing is compromised, since it will not be clear whether expenditures of county-administered funds are higher or lower than projected (see below for further discussion of this point under risk-sharing).

Furthermore, it is necessary to identify the amount of funds that counties/tribes used to match federal Medicaid funds for services such as community support programs and case management where counties/ tribes pay the state share of Medicaid. Counties/tribes must continue to contribute these funds to support the federal dollars we will claim under capitation.

Ultimately it is the implementation of new information systems that will allow counties/tribes to better track and report utilization and expenditures of all funds on a per consumer per service basis. In the meantime, however, we want to use what we learned with our partner counties to assist the demonstration sites to develop a benchmark for the expenditure of county-administered funds. As noted above, this is one of the tasks we wish to undertake during the extended period prior to capitation.

7. Plans for Capitating Community Aids

As noted above, the ability to capitate funds other than Medicaid is constrained by the lack of necessary data. As the demonstrations develop, we assume that better data will become available as a result of improved information systems. As it does, it is the goal of the DHFS to explore extending capitation to community aids dollars in addition to Medicaid. See Attachment 28 for a table indicating the timeline for extending capitation to other funds and to other groups of eligibles.

B. Risk-Sharing and Risk-Reduction

1. Overview

There are numerous strategies that can be incorporated into managed care contracts that reduce risk to the managed care organization. We will review a number of these in this section. However, because risk reduction strategies are intimately tied to the findings of the rate-setting process, *the DHFS cannot make any definitive statements about risk reduction at this time*. We can, however, identify the strategies that the DHFS has used in similar programs and the likelihood that these might be applicable to MH/AODA managed care.

It is important to note at the outset that *the DHFS' ability to share risk is very limited*. Under federal regulations, FFP is available up to the upper payment limit (UPL) only. The upper payment limit is the amount of federal Medicaid dollars that the actuarial analysis projects would have been spent on the target population had they remained in the fee-for-service system during the period of time for which capitated rate payments are made. Regardless of the risk reduction strategy employed, the DHFS cannot expend FFP in excess of this amount.

Similarly, the DHFS' authority to spend state general purpose revenue (GPR) funds is limited to what is provided in the state budget. At this time, the DHFS does not have authority to spend GPR funds in excess of the GPR portion of the Medicaid payments for those services included in the capitation payment (except for the start-up funds identified in Section IV of this RFC).

2. Risk-Adjustment

Risk adjustment refers to a number of mechanisms that can be used to limit the risk an MCO experiences. The DHFS will seek to offer any of the following mechanisms as long as their appropriateness is supported by the actuarial analysis.

a. *Retrospective Rate Adjustments:* Setting an accurate payment rate is complicated by the fact that this will begin as a voluntary program. Capitation rates represent the average cost to serve a member of the target population. However, the actual costs vary among the individuals in that population. If every individual in the population must enroll in the program then the variations, by definition, will average out. However, in a voluntary program it is not possible to know beforehand which individuals will choose to enroll. If the capitation payment is based on the average cost, but the individuals who choose to enroll are those whose costs are above average, the MCO could face large losses. If, on the other hand, the individuals who choose to enroll all have lower than average costs, the MCO may profit, but the State will experience losses, since the State will continue to pay for the higher cost individuals in the fee-for-service system.

Retrospective rate adjustment is a mechanism that allows the DHFS to make retrospective adjustments to payments based on whether the population that actually enrolls is like or not like the expected population. During the demonstration phase the DHFS intends to adjust the payments retrospectively based on the historical fee-for-service costs, trended forward to the demonstration period, of those individuals who actually enroll in the demonstration project. The fee-for-service costs will represent those costs prior to the time the individual enrolled in the MCO, not the costs incurred by the MCO during the time they received capitated payments. The DHFS will work with our actuaries to make actuarially sound adjustments for those individuals without a prior Medicaid claims history. This process may result in an additional payment to the MCO, if the individuals who enroll had higher average fee for service costs prior to enrollment than the average fee-for-service cost on which the capitation rate was based. This process may also result in recoupment of funds from the MCO if the individuals who enroll had lower average fee for service costs prior to enrollment than the average fee-for-service costs on which the capitation rate was based.

b. *Risk-Adjusted Rates*: As can be noted from the actuarial analysis, FFSE costs vary considerably based on objective factors that we can identify (e.g., age, gender). The DHFS will work with our actuaries to determine appropriate ways to risk-adjust rates based on these factors. That is, the MCOs payment will vary based on age, gender or other objective criteria that have a substantive impact on the projected costs. This will increase the likelihood that the MCO is receiving an appropriate payment based on the mixture of individuals who enroll. Risk-adjusted rates are another way to reduce risk in a voluntary program.

c. *Stop-Loss:* The actuarial analysis suggests that there are a small percentage of individuals with very high costs. In a managed care program with small enrollment, which we expect to be the case at

least initially in these demonstrations, the risk associated with these individuals is quite high. However, it is possible to develop an insurance product that will limit the MCO's risk for high-cost individuals. This insurance would set a cap on the amount the MCO would have to pay for any one individual. For instance, the stop-loss might pay 80 percent of expenditures in excess of $50,000, with the MCO paying the remaining 20 percent.

The MCO would pay the premium for this insurance through a reduction in their capitation rates. The DHFS, in conjunction with its actuaries, can develop a variety of stop-loss options. In general, the higher the cap on expenditures and the greater the cost-sharing by the MCO once this cap is reached, the less expensive is the insurance. MCOs could choose levels that they feel best meet their needs.

3. Exemptions

In other managed care programs, the DHFS identifies certain individuals, who by nature of their needs or because of their challenging behaviors, may be exempted from participation in the managed care program. These individuals, then, return to the fee-for-service system. For instance, in our AFDC managed care program, HMOs may request exemption of individuals who seriously threaten providers when providers are attempting to provide care. Other individuals may request exemption for treatment of special conditions, such as individuals with serious mental illness or individuals with AIDS/HIV.

Because this is a voluntary program, the DHFS does not anticipate a need for enrollees to request an exemption—they have the freedom to disenroll from the program. It is also unlikely that someone who does not want treatment, and may threaten people who try to provide treatment, would choose to enroll. Additionally, the MCO would be expected to work with individuals who have been resistant to existing interventions or present challenging behavior—flexible funding and recovery-oriented principles needed to address these situations are an integral part of the demonstrations. Therefore, the DHFS would not expect many situations where the MCO would request exemptions.

Nonetheless, the DHFS will seek input from demonstration sites on appropriate reasons for exemptions. These might include situations where a consumer's medical needs (in a carve-out program) are such that they interfere with the MCO's ability to provide MH/AODA services.

4. Solvency Protection

Solvency protection is the MCO's availability of liquid assets to cover expenditures in excess of revenues and ensure that they can pay providers. Counties/tribes that are operating as MCOs and running carve-out programs (MH/AODA services only) do not need solvency protection during the first year of the MH/AODA managed care demonstration projects. However, by the end of the second year of prepaid, capitated managed care the MCO must have solvency protection equal to 15 percent of projected MCO revenue for the term of that contract year, adjusted to 15 percent of actual revenue within 45 days following the independent audit for that contract period.

The solvency protection shall be accomplished through a cash reserve and through any other means acceptable to the DFHS, including, without limitation, aggregate reinsurance, individual stop loss, lines of credit or parent guarantees.

Carve-in programs are subject to regulation by the Office of the Commissioner of Insurance. Since a program must be a licensed HMO to provide the full range of primary and acute care services, different solvency protection requirements will apply to these programs.

5. Risk-Sharing

Risk-sharing refers to the sharing of costs in excess of revenues between the DHFS and the MCO *after* all risk adjustments have occurred.

In Family Care, the DHFS offered risk-sharing over certain "corridors:"

- The Family Care/Care Management Organization (CMO) is responsible for the first 2 percent of losses.
- The CMO and the DHFS share the next 8 percent of losses on a 50 percent - 50 percent basis.
- The CMO is responsible for losses beyond 10 percent.
- Savings are shared in the same manner as losses.

As noted above, the DHFS cannot share risk beyond the federal UPL or beyond state GPR funds appropriated for this project. Family Care is able to offer this risk sharing only because it reduces the FFSE amount by 2 percent in calculating the capitation payment.

However, there are significant differences between Family Care and MH/AODA managed care that may effect the DHFS' ability to offer this sort of risk-sharing:

- Because Family Care was built to a large degree off the waiver programs, there was somewhat better data on potential eligibles.

- Family Care identified and incorporated community aids costs into the capitation. The CMO will serve its enrollees through the DHFS' capitation—which combines the Medicaid dollars and the community aids dollars--only.

- The presence of significant amounts of county-administered funds and services in MH/AODA managed care makes the settlement process very problematic because of the possibility of cost-shifting. There is a significant burden to counties/tribes and DHFS to agree to whom losses should be attributed.

  Example 1: The MCO requests risk-sharing because expenditures for Medicaid-covered services for Medicaid-covered individuals exceed the total Medicaid revenue. However, on review, the DHFS finds that based on audited financial statements inpatient hospital costs have exceeded the projected FFSE. On further review, the DHFS determines that many of the individuals hospitalized could have been treated in sub-acute care facilities. These costs would have been borne by the county share. As a result, the DHFS disputes that the MCO should be responsible for these costs.

  Example 2: The MCO requests risk-sharing because the expenditures for Medicaid-covered individuals exceed the total Medicaid revenue. However, this is not due to use of Medicaid-covered services. Upon review of the audited financial statements, DHFS notes that this primarily relates to use of mentoring services for children with severe emotional disturbance. Mentors are paraprofessionals who may spend considerable time either individually with a child or with the entire family, implementing a plan of care. The county/tribe argues that these services are producing good outcomes and are provided in lieu of Medicaid-covered services, such as inpatient hospital services or day treatment. The DHFS agrees that it is fair to allocate costs for services that substitute for Medicaid-covered services to the Medicaid portion of expenditures. However, the DHFS argues that while this substitution can be documented in some instances, in other cases the individuals receiving these services would not have met the criteria for these other services. In these cases, the DHFS argues, the costs should be allocated to the county share.

It should also be noted that DHFS does not risk-share for either the Children Come First managed care program in Dane County or WrapAround Milwaukee in Milwaukee County—the two projects most

similar to the proposed MH/AODA managed care demonstrations. The counties are at full risk for costs above the Medicaid capitation and can keep all savings.

At a minimum, risk-sharing by DHFS would require an analysis of county/tribal costs comparable to the analysis to which Medicaid funds have been subjected. It would also require that the county/tribe actually contribute this actuarially determined share to a separate fund for use by the MCO. If counties/tribes are unable to accurately identify current expenditures, there is no basis for claiming whether they have saved or lost money on the demonstrations.

In the absence of a defined and actuarially approved county/tribal contribution, counties/tribes should not assume that the DHFS would engage in risk-sharing for the demonstrations. That is, DHFS would seek a contract through which the MCO is at full risk for expenditures in excess of revenue.

VI. TIMELINE FOR IMPLEMENTATION TASKS: JUNE 2000—DECEMBER 2001

The following is an overview of some of the major activities it is expected that the county/tribe will need to undertake during the first 18 months after being selected in order to make the transition to prepaid, capitated managed care. Certain activities will be limited to the initial demonstration sites, those we are able to provide with start-up funds as described in Sec. IV. However, the DHFS intends to invite all selected sites, the four we are able to fund currently, as well as any other sites whose proposals meet criteria for participation, to participate in other planning activities. In this way, these non-selected sites might be better prepared for entering into managed care contracts should one of the selected sites choose not to proceed or should funding for additional demonstration sites become available in future budgets.

As noted below the DHFS does not anticipate signing final managed care contracts with sites until they are ready to enroll individuals into prepaid, capitated managed care. Any changes to requirements contained in this RFC will be incorporated into the contracts and will not become final until signed by both parties. However, the DHFS will require an addendum to the state-county contract with each site at the point that start-up funding is made available. This addendum will identify the funds the DHFS will make available to the county/tribe, the activities the county/tribe will agree to participate in as part of the planning effort, and any expected outcomes of the process.

The State's 1999-2001 biennial budget has authorized funding for 4 sites—start-up funding for two starting in July 2000 and two in January 2001.

Activity	Participants
June 2000 – December 2000	
Information Technology and Business Requirements—Planning Meetings. Develop business plan identifying organizational changes required to support managed care.	All selected sites[8]
Screening activities.	All selected sites
Identify opportunities to optimize Medicaid billing.	Initial demo sites
Work with Recovery subcommittee to develop "Strategies for Recovery Work Plan."	All selected sites
Recovery subcommittee develops core recovery training curricula in consultation with selected sites.	All selected sites
Develop QI structure.	Initial demo sites

[8] "All selected sites" refers to the four demonstration sites selected through this RFC in addition to other sites that submit acceptable proposals but for whom funding is not currently available. "Initial demo sites" refers to the four demonstration sites that will receive start-up funds during the 1999-2001 biennium. "First demo sites" refers to the two demonstration sites that will receive initial start-up funds on July 1, 2000. "Second demo sites" refers to the two demonstration sites that will receive initial start-up funds on January 1, 2001.

Consultation between Recovery subcommittee and initial demo sites on promoting use of consumer operated services.	Initial demo sites
Collect baseline consumer outcomes information.	Initial demo sites
State-county contract addendum with first demo sites to access start up funds.	First demo sites
Purchase/develop information system (includes beginning to develop claims payment capabilities and reporting capabilities).	First demo sites
Recruit and train consumers and families to serve in governance capacity.	Initial demo sites
Activity	**Participants**
January 2001—June 2001	
Begin rate-setting activities based on screening results.	Initial demo sites
Continue information systems development.	First demo sites
Begin recovery training for key staff.	Initial demo sites
Strategic planning for developing and phasing-in: consumer-operated services; front-end enhancements to the system; dual diagnosis services; enhancements to "non-capitated" part of the system.	Initial demo sites
Form Quality Improvement Committee. Develop QI plan.	Initial demo sites
Implement business plan as developed during prior phase. Will include such things as provider network development, personnel, grievance and appeal processes, member handbook, utilization management.	Initial demo sites (optional for others)
State-county contract addendum with second demo sites to access start-up funds. Second payment to first demo sites.	Second demo sites
Purchase/develop information system (includes beginning to develop claims payment capabilities and reporting capabilities).	Second demo sites
Begin work on developing county share.	First demo sites. (and second?).
Activity	**Participants**
July 2001-December 2001	
Second payments to second demo sites subject to authorization in 2001-2003 biennial budget.	Second demo sites
Complete information systems, claim payment and reporting development.	First demo sites

Complete analysis of Medicaid claims data and establish capitation rate. Establish county share.	First demo sites
Continue information systems development and implementation of business plan	Second demo sites

VII. PROCUREMENT PROCESS

A. Issuing Agency

The RFC is issued for the State of Wisconsin by the Department of Health and Family Services (DHFS). The demonstration projects to be awarded will be administered by the DHFS. The DHFS is the sole point of contact for the State of Wisconsin during the selection process.

B. Who Can Apply

Eligible applicants are:

- Wisconsin counties.
- Wisconsin tribes.
- A consortium formed by two or more counties/tribes to serve two or more counties/tribes,
- A partnership between a county, tribe or consortium of counties and tribes and a licensed Health Maintenance Organization.

The State's 1999-2001 biennial budget limits applicants to entities that currently administer public funds used to provide MH and AODA services to the target populations covered by the demonstrations. This was done in order to achieve the goals noted in Part I of integrating all public funding and building on local systems of care. However, based on our discussions with the Health Care Financing Administration and review of similar programs in other states, the DHFS intends to limit the sole source arrangement to no more than four years. This four year period begins at the point that consumers begin to enroll in prepaid, capitated managed care. After four years (three years if the county/tribe is not meeting minimal acceptable standards to be defined in the contracts), the DHFS intends to request authority to competitively procure this program. Counties and tribes will be welcome to compete and the DHFS believes they will be well positioned to do so if they have been successful in implementing the demonstrations projects.

C. Technical Assistance for Completion of the RFC

Technical assistance regarding the RFC is available on request from:

Shel Gross, MH/AODA Managed Care Policy Analyst
Division of Health Care Financing, Rm. 237
P.O. Box 309
Madison, WI 53701-0309

Phone: 608-266-8473
Fax: 608-261-7792
Email: grosss@dhfs.state.wi.us

While questions may be proposed in any form, the DHFS reserves the right to provide responses in written form only to any questions of a substantive nature that the DHFS believes needs to be identically communicated to all prospective proposers in the interests of fairness.

Technical assistance after the demonstration projects are awarded will be in the form of regular meetings for all the primary and alternate sites together, as well as having State project staff meeting regularly with local project staff, subcontractors, consumers and family members. Other types and the level of technical assistance will be further discussed with the MCOs as we progress.

D. Response to Questions

Written responses to questions will be sent only to counties/tribes submitting a letter of intent (as described below). The entity submitting each question will be identified.

The DHFS intends to issue written responses to questions sent directly to DHFS staff as noted above at the same time as it provides a summary of questions and answers from the Proposers Conference (see below). Because of the short amount of time between the proposers conference and when proposals are due, the DHFS cannot guarantee that we can respond to questions that are submitted after the date of the proposers conference. Proposers are asked to limit such questions to those most important to their preparation of a proposal. The DHFS reserves the right not to respond to questions that would require generation of special reports from management information systems or other time-consuming research.

E. Procurement Timetable

The following is a timeline with events related to the RFC and demonstration projects. This is meant to aid you in submitting a timely and complete RFC.

Date	Events
January 28, 2000	Final RFC released
March 1, 2000	Proposers Conference
March 9, 2000	Letters of Intent due
May 1, 2000	Proposals due to state
June 22, 2000	Award initial and alternate demonstration projects
June 29, 2000	Appeals due

F. Proposers Conference

A proposers conference will be held March 1, 2000, from 9:30 a.m. –12 noon, at the Monona Terrace Community and Convention Center in Madison, WI.

Attendance at the proposers conference is not a mandatory condition for proposal submission, but is recommended. The purpose of the proposers conference is to discuss with prospective proposers the requirements of this RFC and to allow prospective proposers an opportunity to ask questions regarding the MH/AODA managed care demonstration projects and the requirements of this RFC. Questions may be submitted in writing prior to the proposer's conference or presented verbally at the conference. The DHFS will send written responses to questions posed at the proposers conference to all entities submitting a letter of intent. These written responses will be mailed approximately 3 weeks following the proposers conference.

G. Letters of Intent

Counties/tribes expecting to submit a proposal in response to this RFC are strongly encouraged to return a letter of intent by March 9, 2000. Please use the form found in Attachment 29. While a letter of intent is not required, responses to questions from the proposers conference and any subsequent amendments to the RFC will be sent only to counties/tribes submitting a letter of intent. Therefore, failure to submit a letter of intent may result in a county/ tribe's proposal being incomplete or inaccurate in some respects.

H. Amendments to RFC

The DHFS reserves the right to amend the RFC at any time. Amendments will be mailed only to counties/tribes who have submitted a letter of intent.

I. Submission of Proposals

All proposals must be typed in at least 12 point font and include page numbers. The page limits for each part are noted prior to the first question in that respective part of the Program Narrative in Part VIII of this RFC. Respond to the questions in the order they appear in the Program Narrative.

The proposal must include all of the following items. Failure to submit all items is basis for the proposal to be eliminated from the selection process. The Department reserves the right to reject any or all proposals due to incompleteness, or failure to adhere to RFC specifications. The contents of the application packet must be submitted in the following order:

Order of Appearance	Application Item
1st	Commitment to Participate Agreement (Att. 30)
2nd	Application Summary Form (Att. 31)
3rd	Program Narrative (see Sec. VIII)
4th	Personnel of the Demonstration Project Form (Att. 32)
5th	Provider Contracts Form (Att. 33)
6th	County Board/Tribal Council Resolution
7th	Human Services or Community Programs Board Endorsement
8th	Letters of support (from related county/tribal agencies, consumer and family groups)
9th	Workplan (Att. 34)
10th	Detailed Budget Request Forms (Att. 35)
11th	Assurances (Att. 36)
12th	Attachments

The completed application packet is due by May 1, 2000. Applications received after 4:30 p.m. will not be reviewed and will be returned to the applicant. No exceptions will be allowed.

Twelve hard copies (one original and eleven copies) of the application packet must be received at the Department of Health and Family Services. Applications may be mailed or hand delivered. Faxed versions will not be accepted.

The items noted above are to be submitted to:

Shel Gross, MH/AODA Managed Care Policy Analyst
Division of Health Care Financing, Rm. 272
P.O. Box 309
1 West Wilson St.
Madison, WI 53701-0309

Once again, applications received after 4:30 p.m., on May 1, 2000, will not be accepted. No additional information will be accepted from you after the deadline unless it is requested by the DHFS.

J. Withdrawal of Applications

You may withdraw your application by either written notice or in person. An authorized representative may be used providing his/her identity is made known and the person signs a receipt noting the withdrawal.

K. Incurring Costs

The State of Wisconsin is not liable for any cost incurred by you in replying to this RFC.

L. Distribution of Information

It is the intention of the Department to maintain an open and public process in the submission, review and approval of awards. After the demonstration projects have been selected, all material submitted by applicants will be made available for public inspection for two months after the demonstration projects are awarded. Applications will be available for public inspection, under supervision, during the hours of 9am - 4pm at:

Division of Health Care Financing
Bureau of Managed Health Care Programs
1 West Wilson Street, Room 272
Madison, WI

M. News Releases

News releases pertaining to awards and non-awards of demonstration projects or any part of the RFC shall not be made without the prior written approval of the DHFS.

N. Selection Process

The final selection of the demonstration projects will be made by the evaluation committee and the Secretary will decide if a contract will be awarded. Alternate demonstration projects also will be selected. Alternates will become a demonstration project if one of the selected counties/tribes does not participate for various reasons or will be eligible to become a demonstration site when additional sites are authorized by the Legislature.

An evaluation committee consisting of DHFS staff and members external to the DHFS (e.g., consumers and representatives from stakeholder groups) will review the proposals. The first review will be for completeness and adherence to the RFC specifications. Proposals will receive a pass or fail score. Proposals that pass will be scored. The top scoring proposals will be further reviewed and evaluated (e.g., data and reports available to the DHFS, reference checks). In the selection of demonstration projects, consideration will be given to proposals that meet the DHFS's priorities (e.g., integrated vs. carve-out models, rural vs. urban sites). The DHFS may conduct visits with applicant counties/tribes if necessary to distinguish between selected counties/tribes and alternates.

O. Waiver of Informalities

The DHFS reserves the right to reject any or all applications, waive minor informalities, and accept only the most qualified applications in the judgment of the DHFS. The determinations of whether an RFC condition is substantive or a mere informality shall reside solely with the DHFS.

P. Proposer Responses

The DHFS reserves the right to negotiate an award amount, authorized budget items, and specific programmatic goals with the selected applicant prior to entering into an agreement or approving a subcontract agreement. Changes to the requirements outlined in this RFC may occur as a result of further planning efforts, input from HCFA, or decisions made within the DHFS as program development continues. Final requirements will be incorporated into the contracts between the DHFS and the successful proposer.

Justifiable modifications may be made in the course of the agreement only through prior consultation with the written approval of the DHFS. Failure to accept these obligations may result in cancellation of the awarded demonstration project and funding towards the demonstration project.

Q. Notice of Intent to Award Contract

Each applicant will receive written notice, whether or not selected as a demonstration project or alternate. Applicants that are not selected will have an opportunity to discuss the strengths and weaknesses of their application with Sinikka McCabe, Administrator, Division of Support Living.

R. Protest/Appeal Process

Applicants may protest or appeal violation of procedures outlined in this RFC or in the selection process. Subjective interpretations by the evaluation committee are not subject to protest or appeal. Protests must be made in writing and must document the basis for the protest and fully identify the procedural issue being contested. Written notice of intent to protest should be submitted to:

Sinikka McCabe, Administrator
Division of Supportive of Living, Room 550
P.O. Box 7851
Madison, WI 53707-7851

and received no later than five working days after the notification of award is postmarked. The written protest, fully identifying the procedural issue being contested, must be received in the DSL Administrator's office no later than ten (10) working days after the notice of intent is issued.

The decision of the DSL Administrator may be appealed to the Secretary of the Department of Health and Family Services, One West Wilson Street, Room 650, Post Office Box 7850, Madison, Wisconsin 53707 within five (5) days of issuance, with a copy of the protest filed with the DSL Administrator.

S. Post Award Phase

The agreement between the DHFS and the county/tribe will consist of:

- Contents of this RFC,
- Written documents between the DHFS and counties/tribes pursuant to the RFC (e.g., question and answer pieces),
- Application packet in response to the RFC,
- Signed agreement between the DHFS and demonstration project.

Beyond this contractual language, all applicable state and federal laws and regulations apply unless the DHFS has allowed for specific exemptions regarding the demonstration project.

VIII. PROGRAM NARRATIVE

Proposers must respond to all items listed below according to the instructions in Part VII of this RFC. Proposers should respond completely to each section and should not assume reviewers will take into account information from a different section when scoring. There are no absolute limits on response length, though targets are provided.

Questions Regarding Organizational Ability

A. Leadership and staffing

(Target: Two pages **plus** resumes, organizational chart and attachment)

A1. *Project staff:* Who will be the Project Director, the lead clinical staff person and the lead fiscal staff person for the project? Who within the organization will be accountable for the consumer affairs functions identified in Sec. III. E. 3 of the RFC? Identify other staff to the degree this is known at this time. Use the "Personnel of the Demonstration Project" form in Attachment 32 to respond to this and following questions that are related. You may attach resumes of the lead staff noted above in lieu of summarizing their qualifications on Attachment 32.

A2. *Top agency management:* What will be the role of the agency director and deputy director? How much of their time (FTE) will they devote to the project?

A3. *Administering agency and organizational chart:* What organization will administer the project? What other programs does this agency administer? In an organizational chart depict where the project team for the demonstration project is located. This chart must show the relationship of the project team to the rest of the agency, supervisory relationships, and ability to obtain timely fiscal and MIS support.

A4. *Authority of demonstration project staff:* What authority will the project director have to coordinate all aspects of the agency's work in support of this endeavor (e.g., contracting, case management, planning, MIS)?

A5. *Resources of demonstration project staff:* What resources will the project director have available to plan and develop the program? For instance, resources to hold member focus groups, funds for contracting, hiring consultants and conducting studies.

A6. *County board staffing policy:* Is there a current county ceiling on the number of agency employees, or other policies which make it difficult to hire additional county employees? If so, will an exception be made for the demonstration project? Secondly, what alternate methods of getting the job done will be available (e.g., efficient contracting out process)?

A7. *Contracting:* What will the process be for the project director to contract out for additional staff and needed expertise in an effective and efficient way? How long do you estimate it will take on average?

B. Administration and Fiscal Responsibility

(Target: Three pages **plus** program standards waiver request)

B1. *Internal network:* What other parts of the lead agency and county/tribe will have some responsibility for operationalizing a network of providers (e.g., claims adjudication and processing, contract renegotiations) or will in other ways be integral to the success of the demonstration? Specify how each will be involved and affected. If you have a Family Care demonstration in your county how do you plan to coordinate your activities with that program?

B2. External network: What agencies outside the county/tribe will be involved? This should include agencies serving the target population (e.g., housing, agencies on aging, schools, vocational programs) but should exclude agencies providing services covered under this proposal (these will be addressed in section D). Identify each agency and how each will be involved.

B3. *Capitation experience:* Detail relevant instances where the county/tribe has been capitated for any county provided service. Describe the arrangement and the outcome. Describe what you learned from this. If you have not had prior experience with capitation, do you plan to contract or link with HMO's or limited health services organizations (LHSOs—e.g., behavioral health carve-out firms) for services, to provide technical assistance, or to do other functions? Do you plan to subcontract for any administrative functions (e.g., utilization review, network development or management)? Explain how this will be organized.

B4. *Assumption of Financial Responsibility:* How will the county/tribe technically and legally assure that its financial commitments of entering into a contract with the Department that includes increased financial responsibility are met?

B5. *Financial management tools:* Describe the tools and approaches you will use to manage your financial responsibility (e.g., fund reserves).

B6. *Program Standards:* Identify any DHFS program standards you believe you would want to have waived in order to efficiently implement the managed care demonstrations. For each specific standard you want waived identify your rationale and how you will ensure that the health and safety of the consumer will not be adversely affected. This section will not be scored but will serve as the basis for making decisions about waivers if the proposal is successful.

C. Information Systems and Measurement

(Target: Three pages)

C1. *Intake processing:* Describe your existing capacity and future plans to track member based information such as intake and referral data (e.g., referral source, eligibility, referral date, enrollment date) and referrals to other services. How do/will you protect confidentiality of client information?

C2. *Service coordination:* Describe your existing capacity and future plans to capture member based core data to aid service coordination, such as: a) assessments; b) plan of care (e.g., service type, quantity, cost); c) housing arrangement; and d) informal supports.

C3. *Fiscal information:* How does your county/tribe maintain fiscal information for program directors and case managers? What is the link between the fiscal unit/staff and the programs/program staff?

C4. *Administrative:* Describe your existing capacity and future plans to collect data on information related to administrative and management responsibilities such as: a) subcontractors/providers (e.g., utilization by provider); b) revenues and expenditures; c) grievances and appeals tracking.

C5. *Coordination of Benefits:* How will you ensure coordination of benefits with other payers, including Medicare and private insurance? Indicate what success you have had in accessing payment from third parties in the past.

C6. *Claims processing:* Once the subcontracts are in place and rates are agreed upon, describe how you will process the claims of the providers of the services in the benefit package. If your agency will handle this function, provide evidence of your ability to pay claims accurately and promptly (see draft contract for standard claims payment requirements.)

D. Service Availability

(Target: One page **plus** attachment)

D1. *Category A Services:* What existing contracts do you currently have with providers of the category A services listed in the benefit package? Use the "Provider Contracts" form in Attachment 33 to respond to this and following questions that are related. If you don't have contracts for category A services, what are your plans to provide for these (are they provided by your agency)?

D2. *Category B Services:* What contracts do you have for category B services? If you do not currently contract for some of the category B services, do you plan to do so under the demonstrations? If not, how will you address the needs that these services meet?

E. Enrollment

(Target: One page)

E1. *Estimated numbers of enrollees*: Please indicate any limit you would like to place on enrollment into the prepaid-capitated component of the demonstrations. This should be stated as an enrollment limit per plan year (e.g., up to 400 enrollees in year one of the contract; up to an additional 400 enrollees in year two). Please provide the rationale for the enrollment limit requested. Enrollment limits should generally be related to organizational capacity. Identify whether you would like to limit the number of non-Medicaid eligible individuals that you enroll.

What is your best estimate of the total population likely to be eligible to enroll in the prepaid, capitated component of the demonstration (the total number of persons meeting BRC TP 1 and 2 in your county/tribal area?) How long will it take to develop the capacity to enroll this total population?

E2. *Impact on non-capitiated programs:* What impact might enrollment of individuals into the prepaid, capitated component have on individuals remaining in the non-capitated component of the system? How do you intend to maintain your current level of service to the non-capitated population?

Questions Regarding Program Design

F. Populations Included

(Target: Two pages **plus** attachments describing priority populations)

F1. *Age Groups:* Describe the age groups that you will include in the prepaid managed care (e.g., children/adolescents, adult, elderly). Identify the specific age cut-off for these groups. If you plan to phase in the different age groups identify how you would propose to do this (e.g., which group first, when would the next group be added). If you will not be including all age groups identify how you will facilitate the transition of individuals from the prepaid managed care back to the fee-for-service system as they "age-out" of the capitated component.

F2. *Medicaid eligibles:* Which Medicaid eligibility groups will you enroll into the prepaid managed care component? If you wish to phase groups in, please identify how you would propose to do this (e.g., which group(s) first, when would you add the next group). Specifically address inclusion of children in foster care and individuals in nursing homes who may be appropriate for community-based services.

F3. *Priority Populations for Non-Capitated Component:* The non-capitated component of the demonstrations consists of the remainder of the individuals currently served through the 51 system. Please describe the populations you currently serve in your system and include any criteria your county/tribe uses to determine who may receive publicly funded

services (e.g., are any individuals excluded based on diagnosis, severity of illness, etc.). Do you anticipate that these criteria would change as you enter into the demonstration phase? If so, please describe how.

G. Front-End Enhancements

(Target: Two pages)

G1. How do you propose enhancing the front-end of the service system, using the criteria described in Sec. III.C? When will you implement these enhancements? What are your goals and how will you measure them? About how many people do you project will be impacted by these enhancements? How were consumers and family members involved in developing the plan for these enhancements?

If you plan to use a Resource Center similar to the type developed for Family Care, describe whether you are incorporating your resource center into an existing Family Care resource center or developing a new entity. If the former, describe specifically how you will enhance the Family Care resource center to meet the needs of consumers of MH/ AODA services and their families.

Questions Regarding Readiness for the Demonstration Project

H. Track Record of Innovations

(Target: Two pages)

H1. *Innovation:* Describe any innovative approaches and changes you have pioneered that are related to health and human services (e.g., W-2, Wisconsin Partnership Program, wraparound system of care for children). Describe the initiative and the extent of involvement in the initiative. What is the current status, or what was the result of the initiative?

H2. *Areas of excellence:* What particular areas do you believe your county/ tribe excels in? What is the evidence of that excellence?

H3. *Areas for Improvement*: In what areas do you believe your county/tribe could improve and how do you see this demonstration being an opportunity for doing so? How have you identified these areas needing improvement?

I. Readiness for Consumer Choice, Values and Preferences

(Target: Two pages)

I1. *Honoring choice:* Explain how consumer preferences, values and choices are solicited and respected to the extent possible for your consumers and family members and how consumers and family members are informed of these choices.

I2. *Choice of Providers:* Identify how consumers have choice of providers, specifically with regard to service coordinators, service coordination agencies and psychiatrists.

I3. *Developing choice:* How has your county/tribe developed new choices for consumers and families when discovering an inadequate level of choice in your community for services in the benefit package? Please provide specific examples.

I4. *Expandin*g *Choice of providers:* How do you plan to build in additional choice for members to meet their needs during the demonstration? When will you implement these changes?

J. Readiness for Consumer and Family Involvement

(Target: Four pages)

J1. *Systems and program level involvement:* Describe efforts to involve consumers of MH/AODA services and their families in various aspects of the county/tribal system. What has been done in the past to give consumers and families input into MH/AODA services and programs (e.g., involvement on boards/committees, phone survey, focus groups?) To what extent has each medium been utilized? What was done with the consumer's and family members' input and ideas?

J2. *Supporting Consumer and Family Involvement:* How do you recruit, train, reimburse and support consumers or family members to be involved at the program/system level? How will you change this for the demonstrations?

J3. *Consumer and family satisfaction:* How have you gauged consumer and family member satisfaction with the programs and the services received from your programs? Provide detail of each effort (e.g., program, findings, actions taken based on findings). How did you use consumer and family feedback to improve the program?

J4. *Consumer and family involvement in program development and design*: Describe the process you have followed to gather information from consumers and families in the development of your program design and this proposal.

J5. *Consumer and family involvement in policy making boards:* How will you assure that consumers and families will be involved in the ongoing policy development and governance of the demonstration? Describe the make-up of your proposed policy-making board structure and indicate the level of consumer/family involvement that will be sought. If consumers and families are not members of the actual governing board, how will you ensure they have substantive and meaningful input into governance decisions (budgets, hiring of key staff, contracting, etc.). How will you

select consumers and family members to be involved in this governance role?

J6. *Consumer and family involvement in service development:* How will you plan to assess values, desires and preferences of the consumers and family members during the assessment and service planning process? How do you involve informal or natural supports in the care planning process?

J7. *Consumer and family involvement in quality assurance and improvement*: Describe how you will involve consumers and family members initially to set up your QA/QI and outcomes plan. How will they be involved in the monitoring of your outcomes and quality assurance/improvement process?

J8. *Consumers and Families as Employees:* Identify whether you have hired consumers or family members within your organization as either direct service staff or in administrative roles? If so, identify the types of positions that consumers and family members now fill. How will you expand the hiring of consumers and families during the demonstration projects?

J9. *Consumer-Operated Programs*: How has the county/tribe supported the development of consumer-operated programs? Describe the types of programs and the county's/tribe's role in developing and supporting these programs (provides funding, in-kind support such as office space, copying). How does the county/tribe envision developing or expanding consumer-operated programs during the demonstration projects?

J10. *Other means:* Describe any other meaningful ways consumers and families have been involved that were outside the scope of the above questions.

K. Recovery

(Target: Two pages)

K1. Vision of Recovery: Describe your vision of recovery for persons with mental illness and/or alcohol and other drug abuse disorders. What are your key concepts of recovery? How are the concepts of recovery different for persons with mental illness than for persons with AODA disorders? How are they the same?

K2. *Recovery Strategies:* Identify strategies you currently use to foster and support recovery (e.g., use of informal supports, use of advanced directives for emergency care). How will you improve this in the demonstrations?

K3. *Recovery Training:* Identify how you will use existing training opportunities, or create new opportunities, to train providers with regard to recovery concepts and strategies. How will you train consumers and families?

L. Commitment and Support

(Target: Attached resolutions, letters of support)

L1. *County Commitment:* Attach a copy of a county board resolution authorizing the county to submit a proposal for MH/AODA managed care and to participate as a demonstration project, if selected.

L2. *Human Services/Community Programs Board Commitment:* Attach a letter of support from your human services or community programs board.

L3. O*vermatch:* State the amount of 1998 county dollars used as overmatch for MH/AODA. Identify the amount of 1998 dollars that were used as match to state community aids for MH/AODA.

L4. *Consumer and Family Support:* What consumer and family groups are involved in planning for the demonstrations? Please attach letters of support from these organizations.

L5. *Other letters of support:* Append letters of support from the directors of the agencies identified as integral to the success of the demonstration projects in sections B1 and B2.

Questions Regarding the Development of the Demonstration Project

M. Provider Contracts and Relations

(Target: Three pages)

M1. *Provider Contracting:* How will you modify your contracting for services once you are receiving capitated payments? Address changes in payment methods—how you will determine payment rates. How will you use performance-based contracting to determine with whom to contract? If you will not be subcontracting for any services, please describe any changes you will make in how you allocate funds internally to ensure efficiency in service delivery.

M2. *Provider evaluation:* What process will you use for monitoring and evaluating the performance of providers in your network (including your own agency programs/services)?

M3. *Informal supports:* Describe how you utilize informal supports, either paid or unpaid, in assisting consumers meet their needs. Informal supports may be friends, families, neighbors, employers or any other individuals selected by the consumer who is not a paid professional staff person. How will you develop opportunities for informal supports for consumers and families who need them?

M4. *Provider relations and training:* What is your method for strengthening and training your county's/tribe's relationships with your informal and formal providers? How do you identify training needs. Describe any training your staff has done for your informal and formal providers (e.g., ethnic, disability and cultural sensitivity training).

M5. *Cultural and Ethnic Competence*: What ethnic or cultural groups are represented to a significant degree in the population your county/tribe serves? What type of special needs or considerations must be taken into account in providing for the MH/AODA needs of this group? What have you done to date to address these?

M6. *Health care system involvement*

***Carve out programs**:* Describe the formal and informal relationship that your county/tribe has with health care systems (e.g., HMO's, health clinics). Do you have any Memorandums of Understanding or Contracts? If so, please specify. How will you coordinate primary and acute care services for your members? How will you establish working relationships with consumer's primary physicians?

Integrated programs: Who will provide the primary and acute care? What is the nature of the proposed contract between your organization and the organization providing primary and acute care (e.g., which organization will be the primary contractor, will risk be shared between the two organizations, etc.) How will you functionally integrate MH/ AODA care with primary and acute care (e.g., will you attempt to collocate providers)? How will pharmacy benefits, in particular, be handled in your proposed contract (e.g., will the primary and acute care HMO be responsible for all pharmacy costs and, if so, will they approve medications ordered by psychiatrists working for the MH/AODA programs)? How will you ensure that consumers have access to all medications covered by Wisconsin Medicaid, including the atypical anti-psychotic medications?

N. Service System Enhancements

(Target: Four pages)

N1. *Prevention/Early Intervention:* Identify your plan to meet the prevention/early intervention requirements described in Part III. G.2.D.

N2. *Adapting service coordination:* How will you do assessments, service plan development and service coordination differently in light of operating in an environment where you are administering an extensive benefit package with increased financial responsibility? Describe (and include a flow chart) how the consumer and family will move through the system of care from the point of enrollment into prepaid managed care.

N3. *Dispute resolution.* How do you propose to informally resolve disputes between the consumer or family and the rest of the treatment team? Describe the authority the service coordinator will have to authorize services on behalf of the MCO. How do you propose to informally resolve disputes between the recommendations of the treatment and recovery team and you as the payer of services? Describe any use of impartial persons or organizations in this process.

N4. *Service need changes:* How will you respond to consumers whose service needs decrease? How will you ensure that additional services and supports will be made quickly available if needed?

N5. *Consumer education:* Describe your plan to provide education and training to consumers. In your response address: a) areas in which you will provide consumer education; b) who will be providing education; and c) what means will be used to provide the education (e.g., classroom, brochures).

N6. *24-hour access:* How will you provide your members with 24 hour access to emergency care?

N7. *Dual diagnosis services*: How will you enhance services to individuals dually diagnosed with a mental illness and a substance abuse disorder?

N8. *Enhancements to non-capitated portion of the system.* How will you enhance the non-capitated portion of the MCO to improve care management, quality, access and/or efficiency? Be specific about the population targeted, the number of people impacted and how you will measure the outcomes of these enhancements.

N9. *Motivation for enrollment:* What motivation will exist for consumers to choose to enroll in the capitated, prepaid managed care? What opportunities will exist for them under managed care that will not exist under your current system of care?

O. Quality Assurance and Quality Improvement

(Target: Two pages)

O1. *Proposed quality mechanisms:* What is your plan to build a quality assurance system sufficient to administer a demonstration project? At a minimum address: a) composition and function of a QA/I committee; b) probable QA/I studies; and c) data (e.g., what and how to track).

O2. *Quality of service coordination:* Describe the method you will use for measuring the quality of the service coordination activities at your project.

O3. *Implementing improvements:* Describe the process the lead agency will undergo to implement an improvement in the demonstration project that was recommended by the QA/QI committee.

O4. *Existing quality mechanisms:* Describe the processes and mechanisms to ensure quality that are currently in place at the county/tribal level and within the lead agency that will be administering the demonstration project.

O5. *Utilization review:* Describe how you will manage utilization review (e.g., the criteria you would use to determine whether or not to authorize requested services)? Who will have responsibility for reviewing the appropriateness and cost of service plans? How quickly will the treatment and recovery plan be reviewed? How will you respond if the cost of the plan of care exceeds the average cost per consumer (the capitation rate)?

P. Phase-in Plan

(Attachment 34)

P1. *Workplan:* Develop a workplan through the first 18 months following recipient of start-up funds. Use the form provided in Attachment 34 titled "Workplan." Identify how you anticipate developing your infrastructure (MIS, provider network, management staff) to prepare you to undertake a risk-based program. Identify how you will develop your governance structure, QI and other committees and efforts to recruit and train consumers and families to participate.

Q. Budget

(Attachment 35)

Q1. Complete the form in Attachment 35 titled "Budget Request Form." This should reflect your budget for the first year of the project commencing when you receive start-up funding. Please indicate whether you have a preference for receiving start-up funding beginning on July 1, 2000 or January 1, 2001. The DHFS will attempt to accommodate these preferences. If this is not possible (e.g., because all sites prefer receiving start up funds on July 1, 2000) the DHFS will give preference to the sites receiving the higher scores on the evaluation.

Detailed budget information is required to make final decisions on the funding level for each project. Please complete all information on the forms, specifically indicating the estimated annual cost, any in-kind contributions and the amount of requested funding from the start-up funds for each budget item so that we have a complete picture of the estimated costs of implementing a demonstration project. Greater detail in narrative form is required for the following budget items: travel, equipment, supplies and operating expenses, contractual and consultant costs and other expenses.

Summary

(Target: One page)

Provide a brief summary highlighting the information you provided in items A - P. Use this opportunity to summarize your strengths for operating a demonstration project. Essentially, answer the question, "Why would your county/tribe or consortium be an excellent demonstration project?"

Also include a Statement of support for the BRC vision, mission, guiding principles.

The sections of the narrative will be scored as follows:

Section		Total Points
A.	Leadership and Staffing	0
	1:7	pass/fail
B.	Administration and Fiscal Responsibility	35
	1-2: 10 points each	20
	3-5: 5 points each	15
	6: Information only	0
C.	Information Systems and Measurement	30
	1-6: 5 points each	30
D.	Service Availability	20
	1-2: 10 points each	20
E.	Enrollment	15
	5: points	5
	2:10 points	10
F.	Populations Included	45
	1: 10 points for each population included	30
	2: 10 points	10
	5: points	5
G.	Front-End Enhancements	20
	1: 20	20
H.	Track Record of Innovations	15
	1-3: 5 points each	15
I.	Readiness for Consumer Choice, Values, Preferences	35
	1, 3 and 4: 10 points each; 2: 5 points	30 5
J.	Consumer and Family Involvement	50
	1-10: 5 points each	50
K.	Recovery	30
	1. 10 points	10
	2: 10 points	10
	3: 10 points	10
L.	Commitment and Support	10

Section		Total Points
	1-2: pass/fail	Pass/fail
	3-5: 5 points each	15
M.	Provider Contracts and Relations	30
	1-6: 5 points each	30
N.	Service System Enhancements	75
	1, 4, 5, 6, 9: 5 points each	25
	2, 3, 8: 10 points each	30
	7: 20 points	20
O.	Quality Assurance and Quality Improvement	25
	1-5: 5 points each	25
P.	Phase In Plan	20
	1: 20 points	20
Q.	Budget	30
	1. 30 points	30
	Summary	10
Total Points		**500**

IX. OTHER CONDITIONS

A. Compliance with Applicable State and Federal regulations

Unless otherwise specifically waived in writing, the demonstration sites must comply with all applicable State and Federal regulations governing the services provided through the demonstration projects.

B. HCFA Approval

Implementation of the MH/AODA managed care demonstration projects is subject to approval by the Health Care Financing Administration (HCFA). All requirements and recommendations contained in this RFC are subject to modification, as needed, to conform with HCFA requirements.

C. Proposer Responses

Proposals submitted in response to this RFC shall respond to the specifications stated herein. Failure to respond to the specifications may be a basis for a proposal being eliminated from consideration during the selection process.

In the event the proposer is selected as a demonstration site, the contents of this RFC (including all attachments), RFC addenda and revision and the proposal from the successful proposer will become contractual obligations. The DHFS reserves the right to negotiate the award amount, the programmatic goals, and the budget items with the selected proposer prior to entering into an agreement.

Justifiable modifications may be made in the course of the agreement only through prior consultation with and written approval of the DHFS. Failure of the successful proposer to accept these obligations may result in cancellation of the award.

D. Technical Assistance and Oversight Activities

The DHFS anticipates numerous opportunities for providing technical assistance to demonstration sites. We envision that some of these will be provided in a group setting, with all sites together (e.g., identification of business requirements, clarification of reporting requirements). Other technical assistance will be provided through consultation with individual sites. The DHFS expects the MCO to make appropriate staff persons available for these activities. This is not limited to administrative staff of the MCO, but includes provider agencies, front-line staff, and consumer and family representatives. The DHFS will work with demonstration sites to identify times and places for such meetings that are most acceptable to the persons involved and provide adequate notice so that people can arrange their schedules accordingly.

The DHFS believes that it is preferable to identify potential problems as early as feasible. In order to accomplish this the DHFS will seek to have contract monitors on-site at regular times to meet with project management staff as well as to conduct other oversight activities. The DHFS expects the MCO to cooperate with these efforts.

E. Subcontracting

If the applicant plans to use subcontractors, this should be clearly explained in the proposal. However, the primary contractor will be responsible for contract performance whether or not subcontractors are used.

F. Affirmative Action

Successful proposers who are awarded contracts of $25,000 or more shall have included in their contracts the following clause:

A written affirmative action plan is required as a condition for the successful performance of the contract. Excluded from this requirement are grant recipients whose annual work force amount to less than twenty five employees. The affirmative action plan shall be submitted to the DHFS within fifteen (15) working days after the award of the contract.

G. Reasonable Accommodation

The Department will provide reasonable accommodations, including the provision of informational material in alternative format, for qualified individuals with disabilities. For special needs contact:

Shel Gross
Division of Health Care Financing, Rm. 237
P.O. Box 309
Madison, WI 53701-0309
Phone: 608-266-8473
Fax: 608-261-7792
Email: grosss@dhfs.state.wi.us

H. Non-Discrimination Against Employees or Applicants for Employment

In connection with the performance of work under this contract, the successful proposer agrees not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, marital status, physical condition, arrest or conviction record, developmental disability as defined in s. 51.01 (5), sexual orientation or national origin.

However, providers must comply with the requirements of HFS 12 related to background checks, as applicable.

This provision shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship. Except with respect to sexual orientation, the successful proposer further agrees to take affirmative action to ensure equal employment opportunities.

The successful proposer agrees to post in conspicuous places, available for employees and applicants for employment, notice to be provided by the contracting officer setting forth the provisions of the nondiscrimination clause.

I. Year 2000 Compliance

Upon acceptance of a contract as a result of this RFC, the proposer will warrant that: a) all goods, services and licenses sold or otherwise provided have been tested for and are fully year 2000 compliant, which means they are capable of correctly and consistently handling all date-based functions before, during and after the year 2000; b) the date change from 1999 to 2000, or any other date changes, will not prevent such goods, services or licenses for operating in a merchantable manner, for the purposes intended and in accordance with all applicable plans and specification and without interruption before, during and after the year 2000; and c) proposer's internal systems, and those of proposer's vendors, are year 2000 compliant, such that proposer will be able to deliver such goods, services and licenses as required by this RFC.

J. Allowable Costs

A grant recipient will be required to comply with the DHFS Allowable Cost Policy Manual.

K. Termination of Contract

The DHFS may terminate this agreement at any time at its sole discretion by delivering thirty (30) days written notice to the grant recipient. Upon termination, the DHFS' liability will be limited to the pro rata cost of the services performed as of the date of termination plus expenses incurred within the prior written approval of the DHFS. In the event that the grant recipient terminates this agreement, for any reason whatsoever, it will refund to the DHFS within fourteen (14) days of said termination, all payment made hereunder by the DHFS to the grant recipient for work not completed. Such termination will require written notice to that effect to be delivered by the grant recipient to the DHFS not less than thirty (30) days prior to said termination.

L. Good Faith

As noted elsewhere, counties/tribes selected as demonstration sites will not be obligated to enter into contracts for risk-based, capitated Medicaid managed care until they have agreed to all requirements for these contracts, including payment rates and risk requirements. However, counties/tribes responding to this RFC are understood to be doing so in good faith that they will fully participate in the planning and development process with the intent to enter into such contracts.

List of Terminology

1. Capitation: A fixed payment to a managed care organization that must be used to cover the cost of any health care services incurred by enrollees of the MCO that are covered under the contract with the payer. The capitation is usually based on the average projected amount it would cost to serve the enrolled population in a fee-for-service system. The MCO is expected to manage the enrollees care so that all services can be provided with the amount of money received through capitation. The MCO may or may not be at full risk for the capitation amount.

2. Carve-In Programs: Managed care programs that provide primary and acute health care services in addition to MH/AODA services.

3. Carve-Out Programs: Managed care programs that provide MH/AODA services only.

4. Consumer: An individual who is or has been the beneficiary of the provision of structured mental health and/or alcohol and other drug abuse treatment services or activities.

5. Fee-for-service: A payment system in which a provider receives reimbursement for each service he or she delivers. A consumer may receive services from any provider that meets the payers criteria for providing services.

6. Integrated Programs: See 'carve-in programs'.

7. Legal Representative: The legal representative is the consumer's legal guardian per ch. 880, Wis. Stats.; health care agent per ch. 155, Wis. Stats.; or the parent of a minor child.

8. Managed Care Organization (MCO): an entity that is responsible for evaluating the health care needs of its enrollees, arranging and paying for necessary and appropriate services, and managing the enrollees' care in order to achieve specific outcomes in a cost-effective manner.

9. Non- Capitated: See Fee-for-service

10. Recovery: A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. The concept of recovery from illness and disability does not mean that the suffering has disappeared, all the symptoms removed, and/or the functioning completely restored. For example, a person with paraplegia can recover even though the spinal cord has not. Similarly a person with mental illness can recover even though the illness is not cured. (William A. Anthony, Ph.D.)

11. Risk: the extent to which the MCO faces economic loss or gain after agreeing to accept a capitation payment for services. In a full risk contract, the MCO is totally responsible for any expenditures in excess of revenue, but also retains any revenue in excess of expenditures. In a partial risk contract, the payer agrees to make additional payments to

the MCO for some portion of expenditures in excess of revenue but also requires that the MCO return some portion of excess revenue over expenditures.